RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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DATE: December 26, 2019
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WSR 20-02-070

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The agency is amending this chapter to clarify the frequency of reconciliations, and to update timelines standards criteria for enrollment of Rural Health Clinics to include receipt of Medicare certification letter. The agency is also amending this chapter to clarify that the agency covers dental services under 42 C.F.R. 491.2

Citation of rules affected by this order:

New:
Repealed:
Amended: 184-549-1100; 182-549-1200; 182-549-1300; 182-549-1400; 182-549-1450; 182-549-1500
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-23-075 on November 19, 2019 (date).

Describe any changes other than editing from proposed to adopted version: N/A

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:
Phone:
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Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____

The number of sections adopted at the request of a nongovernmental entity:

	New	____	Amended	____	Repealed	____

The number of sections adopted on the agency's own initiative:

	New	____	Amended	____	Repealed	____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	____	Amended	6	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	6	Repealed	____

Date Adopted: December 26, 2019	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 18-10-058, filed 4/27/18, effective 5/28/18)

WAC 182-549-1100 Rural health clinics—Definitions. This section contains definitions of words and 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).

"Base year" - The year that is used as the benchmark in measuring a clinic's total reasonable costs for establishing base encounter rates.

"Encounter" - A face-to-face visit between a client and a qualified ((~~rural health clinic (RHC)~~)) RHC provider (e.g., a physician, dentist, 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 RHC services, paid to a rural health clinic for each valid encounter it bills.

"Enhancements (also called managed care enhancements or supplemental payments)" - A monthly amount paid ((~~for each client enrolled with a managed care organization (MCO). MCOs may contract with RHCs to provide services under managed care programs. RHCs receive enhancements from the medicaid agency in addition to the negotiated payments they receive from the MCOs for services provided to enrollees~~)) by the agency to RHCs through a managed care organization (MCO) that has contracted with the RHC to provide services to clients enrolled with the MCO. The enhancement is in addition to the negotiated payment that RHCs receive from the MCO. RHCs participating in the payment method described in WAC 182-549-1450 (5)(b) do not receive enhancements.

"Fee-for-service" - A payment method the agency uses to pay providers for covered medical services provided to clients enrolled in the Title XIX (medicaid) program or the Title XXI (CHIP) program, except those services provided under the agency's prepaid managed care organizations or those services that qualify for an encounter payment.

"Interim rate" - The rate established by the agency to pay a rural health clinic for covered RHC services prior to the establishment of a permanent rate for that facility.

"Medicare cost report" - The cost report is a statement of costs and provider utilization that occurred during the time period covered by the cost report. RHCs must complete and submit a report annually to medicare.

"Mobile unit" - The objects, equipment, and supplies necessary for provision of the services furnished directly by the RHC are housed in a mobile structure.

"Permanent unit" - The objects, equipment, and supplies necessary for the provision of the services furnished directly by the RHC are housed in a permanent structure.

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

"Rural area" - An area that is not delineated as an urbanized area by the U.S. Census Bureau.

"Rural health clinic (RHC)" - A clinic, as defined in 42 C.F.R. 405.2401(b), that is primarily engaged in providing RHC services and is:

• Located in a rural area designated as a shortage area as defined under 42 C.F.R. 491.2;

• Certified by medicare as an RHC in accordance with applicable federal requirements; and

• Not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

"Rural health clinic (RHC) services" - Outpatient or ambulatory care of the nature typically provided in a physician's office or outpatient clinic or similar setting, including specified types of diagnostic examination, laboratory services, and emergency treatments. The specific list of services which must be made available by the clinic can be found under 42 C.F.R. Part 491.9.

AMENDATORY SECTION (Amending WSR 15-11-008, filed 5/7/15, effective 6/7/15)

WAC 182-549-1200 Rural health clinics—Enrollment. (1) To participate in the Title XIX (medicaid) program or the Title XXI (CHIP) program and receive payment for services, a rural health clinic (RHC) must:

(a) Receive RHC 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;

(c) Comply with the clinical laboratory improvement amendments (CLIA) of 1988 testing for all laboratory sites per 42 C.F.R. Part 493; and

(d) Operate in accordance with applicable federal, state, and local laws.

(2) An RHC may be a permanent or mobile unit. If an entity owns clinics in multiple locations, each individual site must be certified by the ((~~medicaid~~)) agency in order to receive reimbursement from the agency as an RHC.

(3) The agency uses one of two timeliness standards for determining the effective date of a medicaid-certified RHC.

(a) The agency uses medicare's effective date if the RHC returns a properly completed core provider agreement and RHC enrollment packet within sixty days from the date of medicare's letter notifying the clinic of the medicare certification.

(b) The agency uses the date the ((~~signed core provider agreement is received~~)) medicare certification letter is received by the agency if the RHC returns the properly completed core provider agreement and RHC enrollment packet after sixty days of the date of medicare's letter notifying the clinic of the medicare certification.

AMENDATORY SECTION (Amending WSR 15-11-008, filed 5/7/15, effective 6/7/15)

WAC 182-549-1300 Rural health clinics—Services. (1) Rural health clinic (RHC) services are defined under 42 C.F.R. 440.20(b).

(2) The medicaid agency pays for RHC services when they are:

(a) Within the scope of a client's benefit package. ((~~Refer to~~)) See WAC 182-501-0060; and

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

(3) RHC services may be provided by any of the following individuals in accordance with 42 C.F.R. 405.2401, 491.7, and 491.8:

(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 (RN) or licensed practical nurses (LPN); ((~~and~~))

(g) Psychologists or clinical social workers; and

(h) Dental services specified in 42 C.F.R. Sec. 440.100.

AMENDATORY SECTION (Amending WSR 17-12-016, filed 5/30/17, effective 7/1/17)

WAC 182-549-1400 Rural health clinics—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 rural health clinics (RHC) 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, RHCs have the choice to be reimbursed under the PPS or 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~~)) are at least as much as payments that would have been made under the PPS.

(3) The agency calculates RHC PPS encounter rates for RHC core services as follows:

(a) Until an ((~~RHC's~~)) RHC submits its first audited medicare cost report ((~~is available~~)) to the agency, the agency pays the RHC an average encounter rate of other similar RHCs ((~~(whether the RHC is classified as hospital-based or free-standing)~~)) within the state, otherwise known as an interim rate. Similar RHCs are defined as either all hospital based or all free-standing RHCs;

(b) Upon ((~~availability~~)) submission of the RHC's first audited medicare cost report, the agency sets RHC's encounter rates at one hundred percent of its costs as defined in the cost report divided by the total number of encounters the RHC has provided during the time period covered in the audited cost report. RHCs receive this rate for the remainder of the calendar year during which the audited cost report became available to the agency. The agency then increases the encounter rate ((~~is then increased~~)) each January 1st by the percent change in the medicare economic index (MEI).

(4) For RHCs in existence during calendar years 1999 and 2000, the agency sets the encounter rates prospectively using a weighted average of one hundred percent of the RHC'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 182-549-1500.

(b) PPS base encounter rates are determined using medicare's 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:

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

(c) Beginning in calendar year 2002 and any year thereafter, encounter rates are increased by the MEI and adjusted for any increase or decrease in the RHC's scope of services.

(5) The agency ((~~calculates~~)) calculated RHC's APM encounter rates for services provided during the period beginning January 1, 2009, and ending April 6, 2011, as follows:

(a) The APM ((~~utilizes~~)) used the RHC base encounter rates as described in subsection (4)(b) of this section.

(b) Base rates ((~~are~~)) were increased by each annual percentage, from calendar years 2002 through 2009, of the IHS Global Insight index, also called the APM index.

(c) The result ((~~is~~)) was the year 2009 APM rates for each RHC that ((~~chooses~~)) chose to be reimbursed under the APM.

(6) This subsection describes the encounter rates that the agency ((~~pays~~)) paid RHCs 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 RHCs at the encounter rate described in subsection (5) of this section.

(b) Each RHC ((~~has~~)) had 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~~)) used each RHC'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~~)) recouped from RHCs any amount paid in excess of the encounter rate established in this section. This process ((~~is~~)) was 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 rate that the agency pays RHCs 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 RHC 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 RHCs 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 RHCs 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 RHCs receiving their initial RHC designation after 2002) increased 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 calendar years 2009 through 2011. The rates ((~~will be~~)) are increased by the MEI effective January 1, 2012, and 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~~)) recouped from RHCs any amount paid in excess of the encounter rate established in this section. This process ((~~is~~)) was specified in emergency rules that took effect on October 29, 2011, (WSR 11-22-047) and February 25, 2012 (WSR 12-06-002).

(d) For RHCs that choose to be paid under the revised APM, the agency ((~~will~~)) periodically rebases the encounter rates using the RHC cost reports and other relevant data. Rebasing ((~~will be~~)) is done only for RHCs that are reimbursed under the APM.

(e) The agency ((~~will ensure~~)) makes sure 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 RHCs for services provided beginning July 1, 2017.

(a) Each RHC 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 is as follows:

(i) The revised APM establishes a budget-neutral, baseline per member per month (PMPM) rate for each RHC. 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 RHC a PMPM payment each month for each managed care client assigned to them by an MCO.

(iii) The agency pays the RHC a PMPM payment each month in addition to the amounts the MCO pays the RHC.

(iv) The agency may prospectively adjust the RHC's PMPM rate for any of the following reasons:

(A) Quality and access metrics performance.

(B) RHC encounter rate changes.

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

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

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

AMENDATORY SECTION (Amending WSR 17-22-070, filed 10/27/17, effective 1/1/18)

WAC 182-549-1450 Rural health clinics—General payment information. (1) The medicaid agency pays for one encounter, 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.

(2) Rural health clinic (RHC) services and supplies incidental to the provider's services are included in the encounter rate payment.

(3) The agency pays for non-RHC services provided in an RHC on a fee-for-service basis using the agency's published fee schedules. Non-RHC services are subject to the coverage guidelines and limitations listed in chapters 182-500 through 182-557 WAC.

(4) For clients enrolled with a managed care organization (MCO), that MCO pays for covered RHC services ((~~are paid for by the MCO~~)).

(5) For clients enrolled with MCOs, the RHC receives an encounter rate using either the method described in (a) or (b) of this subsection.

(a) ((~~The agency makes supplemental payments, called enhancements, to the MCOs who distribute them to the RHCs. These payments are in addition to the amounts paid to the RHC by the MCO as described in subsection (4) of this section.~~)) RHCs receive an enhancement payment in addition to the MCO's negotiated payment. The ((~~supplemental~~)) agency makes enhancement payments ((~~are paid~~)) in amounts necessary to ((~~ensure~~)) make sure that the RHC receives the full encounter rate to comply with 42 U.S.C. 1396a (bb)(5)(A).

(i) The RHCs receive a monthly enhancement payment for each managed care client assigned to them by an MCO.

(ii) To ((~~ensure~~)) make sure that each RHC receives the appropriate amounts ((~~are paid to each RHC~~)), the agency performs an annual reconciliation of the enhancement payments. For each RHC, the agency ((~~will~~)) compares the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less the fee-for-service equivalent of MCO services. If the RHC has been overpaid, the agency ((~~will~~)) recoups the appropriate amount. If the RHC has been underpaid, the agency ((~~will~~)) pays the difference. For dates of service on and after January 1, 2018, reconciliations ((~~will be~~)) are conducted in the calendar year following the calendar year for which the enhancements were paid. Reconciliations ((~~will be~~)) are conducted by the agency or the clinic with final review and approval by the agency. The process of settling over or under payments may extend beyond the calendar year in which the reconciliations were conducted.

(b) Effective January 1, 2018, instead of distributing monthly enhancement payments to the RHCs, MCOs ((~~will~~)) pay the full encounter rate directly to participating clinics for encounter-eligible services.

(i) RHC participation in this option is voluntary. The RHC must notify the agency in writing whether it will participate or not by no later than November 1st prior to the year of participation.

(ii) The agency performs ((~~an annual~~)) a reconciliation with the MCO as outlined in the MCO contract. Reconciliations ((~~ensure~~)) make sure appropriate amounts are paid to each RHC and that MCOs are not

put at risk for, or have any right to, the enhancement portion of the claim. If an MCO has been overpaid, the agency ((~~will~~)) recoups the appropriate amount. If an MCO has been underpaid, the agency ((~~will~~)) pays the difference.

(iii) RHCs participating in the revised alternative payment method (APM) as described in WAC 182-549-1400(8) ((~~will~~)) are not ((~~be~~)) eligible to receive encounter payments directly from MCOs under this section.

(6) Only those services provided to clients enrolled in the Title XIX (medicaid) program or the Title XXI (CHIP) program are eligible for encounter or enhancement payments. The agency does not pay the encounter rate or the enhancement rate for services provided to 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.

AMENDATORY SECTION (Amending WSR 15-05-020, filed 2/9/15, effective 3/12/15)

WAC 182-549-1500 Rural health clinics—Change in scope of service rate adjustment. In accordance with 42 U.S.C. 1396a (bb)(3)(B), the agency ((~~will~~)) adjusts its payment rate to a rural health clinic (RHC) to take into account any increase or decrease in the scope of the RHC's services. The procedures and requirements for any such rate adjustment are described below.

(1) **Triggering events.**

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

(i) The cost to the RHC 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 RHC provides;

(B) A change in the intensity of health care services the RHC 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 RHC provides. Duration means the length of an average encounter has increased;

(D) A change in the amount of health care services the RHC 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 state and federal law.

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

(i) The RHC must file a completed cost report and position statement no later than ninety calendar days after receiving the instruction from the agency to file an application;

(ii) The agency reviews the RHC'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~~)) does not request more than one change in scope in a calendar year.

(2) **Filing requirements.**

(a) The RHC 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 RHC 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 RHC 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 RHC believes the change in scope occurred or in which the RHC learned 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 RHC must submit projected costs sufficient to establish an interim rate. A prospective change is a change the RHC plans to implement in the future. The interim rate adjustment ((~~will go~~)) goes 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 RHC 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) If the change in scope occurs more than ninety days but fewer than one hundred eighty days after the RHC submitted a complete application to the agency, the interim rate takes effect when the change in scope occurs.

(v) If the RHC 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 RHC 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 RHC is seeking to adjust its rate based on that change.

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

(3) **Supporting documentation.**

(a) To apply for a change in scope of service rate adjustment, the RHC 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 RHC'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 a 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 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~~)) reviews the application for completeness, accuracy, and compliance with program rules.

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

(iii) Within ninety days of receiving a complete application, the agency ((~~must~~)) sends the RHC:

(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~~)) means that the change is considered denied by the agency and the RHC may appeal the decision as provided for in subsection (6) of this section.

(b) Determining rate for change in scope.

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

(ii) The agency ((~~must~~)) sets an adjusted encounter rate for retrospective changes in scope by adjusting the RHC'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~~)) reviews the costs to determine whether they are reasonable, and sets a new rate based on the determined cost per encounter.

(c) If the RHC is paid under an alternative payment methodology (APM), any change in scope of service rate adjustment ((~~requested~~)) approved by the ((~~RHC will modify~~)) 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 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 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 based on less than a full year of actual encounter data, the RHC must submit the following information to the agency within eighteen months of the effective date of the rate adjustment:

(i) 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~~)) conducts the post change in scope review within ninety days of receiving the cost report and encounter data from the RHC.

(d) If necessary, the agency ((~~will~~)) adjusts the encounter rate within ninety days to ((~~ensure~~)) make sure 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~~)) takes effect on the date the agency issues its adjustment. The new rate ((~~will be~~)) is prospective.

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

(g) If the RHC fails to submit required documentation within five months of this deficiency notice, the agency may reinstate the pre-change in scope encounter rate going forward from the date the interim rate was established. The agency may recoup any overpayment to the RHC ((~~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.