DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

JUN 26 2009

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

**RE: Washington State Plan Amendment (SPA) Transmittal Number #08-010**

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services has completed our review of State Plan Amendment (SPA) Transmittal Number #08-010.

This amendment implements an alternative payment methodology (APM) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). The APM and Prospective Payment System (PPS) will be reconciled annually to ensure the APM at least equals the PPS rate.

This SPA is approved effective July 1, 2008, as requested by the State.

I appreciate the significant amount of work that your staff dedicated to getting this SPA approved and the cooperative way in which we achieved this much-desired outcome. If you have any questions concerning this SPA, please contact me at (206) 615-2267 or have your staff contact Mary Jones at (360) 486-0243 or Mary.Jones2@cms.hhs.gov.

Sincerely,

Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Douglas Porter, Assistant Secretary, Health and Recovery Services Administration
Louis McDermott, Chief, Office of Rates Development, Health and Recovery Services Administration

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: **08-010**

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
July 1, 2008

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 2008 $0
b. FFY 2009 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B pages 3, 4, 5, 33 (P+I), 34, 35 ~~1~~ (P+I) (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B pages 3, 4, 5, 33 (P+I), 34, 35 ~~1~~ (P+I) (P+I)

10. SUBJECT OF AMENDMENT:

FQHC & RHC Updates

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:
Robin Arnold-Williams

13. TYPED NAME:
ROBIN ARNOLD-WILLIAMS

14. TITLE:
Secretary

15. DATE SUBMITTED:
May 29, 2008

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

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: MAY 29 2008

18. DATE APPROVED: JUN 26 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2008

20. SIGNATURE OF REGIONAL OFFICIAL:
Barbara K. Richards

21. TYPED NAME:
Barbara K. Richards

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

23. REMARKS:

Pen and Ink changes authorized by the state 6/10/2009
Pen and Ink changes authorized by the state 6/15/09

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 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 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, which were established in 2002 using the PPS methodology in place at the time. The base rates were calculated using data from 1999 and 2000, 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 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 clinics' base encounter rates.

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 chose the APM.

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.

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.)

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 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.

C. 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.

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, which were established in 2002 using the PPS methodology in place at the time. The base rates were calculated using data from 1999 and 2000 and, in some cases, 2001. 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.

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.

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 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.

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 clients enrolled with a managed care contractor, the State will pay the center 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 center, 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). This process will apply to centers under the APM and to centers under the PPS. 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 provided to Medicaid-Medicare patients are reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.