RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Health Care Authority, Washington Apple Health

Permanent Rule Only

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) July 1, 2017 **(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 these rules in response to ESSHB 2572, which directs the agency to increase the use of value-based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement for Medicaid purchasing. To improve clarity, the agency moved existing rule language from WACs 182-548-1400 and 182-549-1400 to new section numbers with new titles: 182-548-1450 FQHC – General payment information; 182-549-1450 RHC – General payment information.

Citation of existing rules affected by this order:

Repealed:

Amended: 182-548-1400, 182-549-1400

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 17-09-060 on April 18, 2017.

Describe any changes other than editing from proposed to adopted version: None

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

Name: phone ( ) _____

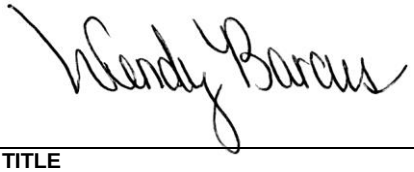
Address: fax ( ) _____

e-mail _____

Date adopted: May 30, 2017

NAME (TYPE OR PRINT)
Wendy Barcus

SIGNATURE



TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 30, 2017
TIME: 10:07 AM

WSR 17-12-016

(COMPLETE REVERSE SIDE)

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Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	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 in the agency's own initiative:

New _____ Amended _____ Repealed _____

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

New 2 Amended 2 Repealed _____

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	2	Amended	2	Repealed	

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

WAC 182-548-1400 Federally qualified health centers—((~~Reimbursement and limitations~~)) Payment methodologies. (1) For services provided during the period beginning January 1, 2001, and ending December 31, 2008, the medicaid agency's payment methodology for federally qualified health centers (FQHC) 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, FQHCs have the choice to be reimbursed under the PPS or to 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 at least as much as payments that would have been made under the PPS.

(3) The agency calculates FQHC PPS encounter rates as follows:

(a) Until an FQHC's first audited medicaid cost report is available, the agency pays an average encounter rate of other similar FQHCs within the state, otherwise known as an interim rate((~~;~~)).

(b) Upon availability of the FQHC's first audited medicaid cost report, the agency sets FQHC encounter rates at one hundred percent of its total reasonable costs as defined in the cost report. FQHCs receive this rate for the remainder of the calendar year during which the audited cost report became available. The encounter rate is then increased each January 1st by the percent change in the medicare economic index (MEI).

(4) For FQHCs in existence during calendar years 1999 and 2000, the agency sets encounter rates prospectively using a weighted average of one hundred percent of the FQHC'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 182-548-1500.

(b) PPS base encounter rates are determined using 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:

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

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

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

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

(b) Base rates are adjusted to reflect any approved changes in scope of service in calendar years 2002 through 2009.

(c) The adjusted base rates are then increased by each annual percentage, from calendar years 2002 through 2009, of the IHS Global

Insight index, also called the APM index. The result is the year 2009 APM rate for each FQHC that chooses to be reimbursed under the APM.

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

(b) Each FQHC 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 (c) of this subsection.

(c) The revised APM uses each FQHC'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 from FQHCs any amount in excess of the encounter rate established in this section. This process is 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 rates that the agency pays FQHCs 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 FQHC 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 FQHCs 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 FQHCs 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 FQHCs receiving their initial FQHC designation after 2002) increased by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and by the cumulative percentage increase in the MEI from calendar years 2009 through 2011. The rates were increased by the MEI effective January 1, 2012, and will be increased by the MEI 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 from FQHCs any amount paid in excess of the encounter rate established in this section. This process is specified in emergency rules that took effect on October 29, 2011, (WSR 11-22-047) and February 25, 2012 (WSR 12-06-022).

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

(e) The agency will ensure that the payments made under the APM are at least equal to the payments that would be made under the PPS.

(8) ((~~The agency limits encounters to one 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.~~

~~(9) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.~~

~~(10) Fluoride treatment and sealants must be provided on the same day as an encounter-eligible service. If provided on another day, the rules for non-FQHC services in subsection (11) of this section apply.~~

~~(11) Payments for non-FQHC services provided in an FQHC are made on a fee-for-service basis using the agency's published fee schedules. Non-FQHC services are subject to the coverage guidelines and limitations listed in chapters 182-500 through 182-557 WAC.~~

~~(12) For clients enrolled with a managed care organization (MCO), covered FQHC services are paid for by that plan.~~

~~(13) For clients enrolled with an MCO, the agency pays each FQHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).~~

~~(a) The FQHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.~~

~~(b) To ensure that the appropriate amounts are paid to each FQHC, the agency performs an annual reconciliation of the enhancement payments. For each FQHC, the agency will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less fee-for-service equivalent of MCO services. If the FQHC has been overpaid, the agency will recoup the appropriate amount. If the FQHC has been underpaid, the agency will pay the difference.~~

~~(14) Only clients enrolled in Title XIX (medicaid) or Title XXI (CHIP) are eligible for encounter or enhancement payments. The agency does not pay the encounter rate or the enhancement rate for 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.~~)) This subsection describes the payment methodology that the agency uses to pay participating FQHCs for services provided beginning July 1, 2017.

(a) Each FQHC 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 FQHC. 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 FQHC a PMPM payment each month for each managed care client assigned to them by an MCO.

(iii) The agency pays the FQHC a PMPM rate in addition to the amounts the MCO pays the FQHC. The agency may prospectively adjust the FQHC's PMPM rate for any of the following reasons:

(A) Quality and access metrics performance.

(B) FQHC encounter rate changes.

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

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

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

NEW SECTION

WAC 182-548-1450 Federally qualified health centers—General payment information. (1) The agency limits encounters to one 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) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(3) Fluoride treatment and sealants must be provided on the same day as an encounter-eligible service. If provided on another day, the rules for non-FQHC services in subsection (4) of this section apply.

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

(5) For clients enrolled with a managed care organization (MCO), covered FQHC services are paid for by that plan.

(6) For clients enrolled with an MCO, the agency pays each FQHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

(a) The FQHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.

(b) To ensure that the appropriate amounts are paid to each FQHC, the agency performs an annual reconciliation of the enhancement payments. For each FQHC, the agency will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less fee-for-service equivalent of MCO services. If the FQHC has been overpaid, the agency will recoup the appropriate amount. If the FQHC has been underpaid, the agency will pay the difference.

(7) Only clients enrolled in Title XIX (medicaid) or Title XXI (CHIP) are eligible for encounter or enhancement payments. The agency does not pay the encounter rate or the enhancement rate for 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 15-11-008, filed 5/7/15, effective 6/7/15)

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 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 first audited medicare cost report is available, the agency pays 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.

(b) Upon availability 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. 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:

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

(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 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 the RHC base encounter rates as described in subsection (4)(b) of this section.

(b) Base rates are 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 the year 2009 APM rates for each RHC that chooses to be reimbursed under the APM.

(6) This subsection describes the encounter rates that the agency pays 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 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 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 from RHCs any amount paid in excess of the encounter rate established in this section. This process is 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 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 from RHCs any amount paid in excess of the encounter rate established in this section. This process is 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 rebase the encounter rates using the RHC cost reports and other relevant data. Rebasing will be done only for RHCs that are reimbursed under the APM.

(e) The agency will ensure that the payments made under the APM are at least equal to the payments that would be made under the PPS.

(8) ((~~The 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.~~

~~(9) RHC services and supplies incidental to the provider's services are included in the encounter rate payment.~~

~~(10) Payments for non-RHC services provided in an RHC are made 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.~~

~~(11) For clients enrolled with a managed care organization (MCO), covered RHC services are paid for by that plan.~~

~~(12) For clients enrolled with an MCO, the agency pays each RHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).~~

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

~~(b) To ensure that the appropriate amounts are paid to each RHC, the agency performs an annual reconciliation of the enhancement payments. For each RHC, the agency will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less fee-for-service equivalent of MCO services. If the RHC has been overpaid, the agency will recoup the appropriate amount. If the RHC has been underpaid, the agency will pay the difference.~~

~~(13) Only 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 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.~~)) 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. 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) 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) of this subsection.

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

NEW SECTION

WAC 182-549-1450 Rural health clinics—General payment information. (1) The 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) RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(3) Payments for non-RHC services provided in an RHC are made 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), covered RHC services are paid for by that plan.

(5) For clients enrolled with an MCO, the agency pays each RHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

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

(b) To ensure that the appropriate amounts are paid to each RHC, the agency performs an annual reconciliation of the enhancement payments. For each RHC, the agency will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less fee-for-service equivalent of MCO services. If the RHC has been overpaid, the agency will recoup the appropriate amount. If the RHC has been underpaid, the agency will pay the difference.

(6) Only 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 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.