

Chapter 182-549 WAC
RURAL HEALTH CLINICS

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WAC

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WAC 182-549-1000 Rural health clinics—Purpose. This chapter establishes the medicaid agency's reimbursement methodology for rural health clinic (RHC) services. RHC conditions for certification are found in 42 C.F.R. Part 491.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-11-008, § 182-549-1000, filed 5/7/15, effective 6/7/15. WSR 11-14-075, recodified as § 182-549-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. WSR 08-05-011, § 388-549-1000, filed 2/7/08, effective 3/9/08.]

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.

"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) provider (e.g., a physician, 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.

"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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-10-058, § 182-549-1100, filed 4/27/18, effective 5/28/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2017 3rd sp.s. c 1 § 213(1)(11). WSR 17-22-070, § 182-549-1100, filed 10/27/17, effective 1/1/18. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-11-008, § 182-549-1100, filed 5/7/15, effective 6/7/15. WSR 11-14-075, recodified as § 182-549-1100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 U.S.C. 1396a(bb), 42 C.F.R. 405.2472, and 42 C.F.R. 491. WSR 10-09-030, § 388-549-1100, filed 4/13/10, effective 5/14/10. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. WSR 08-05-011, § 388-549-1100, filed 2/7/08, effective 3/9/08.]

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;

(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 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-11-008, § 182-549-1200, filed 5/7/15, effective 6/7/15. WSR 11-14-075, recodified as § 182-549-1200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. WSR 08-05-011, § 388-549-1200, filed 2/7/08, effective 3/9/08.]

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 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 or licensed practical nurses; and

(g) Psychologists or clinical social workers.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-11-008, § 182-549-1300, filed 5/7/15, effective 6/7/15. WSR 11-14-075, recodified as § 182-549-1300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. WSR 08-05-011, § 388-549-1300, filed 2/7/08, effective 3/9/08.]

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 Cen-

ters 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) 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-12-016, § 182-549-1400, filed 5/30/17, effective 7/1/17; WSR 15-11-008, § 182-549-1400, filed 5/7/15, effective 6/7/15. Statutory Authority: RCW 41.05.021. WSR 12-16-060, § 182-549-1400, filed 7/30/12, effective 8/30/12. WSR 11-14-075, recodified as § 182-549-1400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 U.S.C. 1396a(bb), 42 C.F.R. 405.2472, and 42 C.F.R. 491. WSR 10-09-030, § 388-549-1400, filed 4/13/10, effective 5/14/10. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. WSR 08-05-011, § 388-549-1400, filed 2/7/08, effective 3/9/08.]

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), 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. The supplemental payments are paid in amounts necessary to ensure 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 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. For dates of service on and after January 1, 2018, reconciliations will be conducted in the calendar year following the calendar year for which the enhancements were paid. Reconciliations will be 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 reconciliation with the MCO as outlined in the MCO contract. Reconciliations ensure 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 recoup the appropriate amount. If an MCO has been underpaid, the agency will pay the difference.

(iii) RHCs participating in the revised alternative payment method (APM) as described in WAC 182-549-1400(8) will 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.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2017 3rd sp.s. c 1 § 213(1)(11). WSR 17-22-070, § 182-549-1450, filed 10/27/17, effective 1/1/18. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-12-016, § 182-549-1450, filed 5/30/17, effective 7/1/17.]

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 adjust 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 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 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 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 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 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 review the application for completeness, accuracy, and compliance with program rules.

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

(iii) Within ninety days of receiving a complete application, the agency must send 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 mean 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 set 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 review the costs to determine if they are reasonable, and set a new interim rate based on the determined cost per encounter.

(ii) The agency must set 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 review the costs to determine whether they are reasonable, and set 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 by the RHC will modify 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 conduct 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 adjust the encounter rate within ninety days to ensure 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 take effect on the date the agency issues its adjustment. The new rate will be prospective.

(f) If the RHC fails to submit the post change in scope cost report or related encounter data, the agency must provide 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. 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.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 15-05-020, § 182-549-1500, filed 2/9/15, effective 3/12/15. WSR 11-14-075, recodified as § 182-549-1500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 U.S.C. 1396a(bb), 42 C.F.R. 405.2472, and 42 C.F.R. 491. WSR 10-09-030, § 388-549-1500, filed 4/13/10, effective 5/14/10. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. WSR 08-05-011, § 388-549-1500, filed 2/7/08, effective 3/9/08.]