

## **Table of Contents**

**State/Territory Name: Washington**

**State Plan Amendment (SPA) #: 24-0041**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
601 E. 12th St., Room 355 (300)  
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

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December 3, 2024

Susan Birch, Director  
Dr. Charissa Fotinos, State Medicaid Director  
Washington State Health Care Authority  
Post Office Box 45502  
Olympia, WA 98504-5010

Re: Washington State Plan Amendment (SPA) – 24-0041

Dear Director Birch and Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0041. This amendment will revise out-of-date transplant coverage policies to conform to industry standards and government practices to the Medicaid State Plan.

We conducted our review of your submittal according to statutory requirements in Section 1903(i) of the Act and 42 CFR 441.35. This letter informs you that Washington State Plan Amendment (SPA) – 24-0041 was approved on December 3, 2024, with an effective date of January 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Washington State Plan.

If you have any questions, please contact Edwin Walaszek at (212)-616-2512 or via email at [edwin.walaszek1@cms.hhs.gov](mailto:edwin.walaszek1@cms.hhs.gov).

Sincerely,

A black rectangular box redacts the signature of James G. Scott.

Digitally signed by James  
G. Scott -S  
Date: 2024.12.03 16:12:16  
-06'00'

James G. Scott, Director  
Division of Program Operations

Enclosures

cc: Ann Myers, Section Manager & State Plan Coordinator, Health Care Authority

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 4 — 0 0 4 1

2. STATE

WA3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL  
SECURITY ACT

XIX



XXI

TO: CENTER DIRECTOR

CENTERS FOR MEDICAID &amp; CHIP SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION

~~1902a of the Social Security Act, 42 CFR parts 121 and 482~~  
Section 1903(i) of the Act and 42 CFR 441.35

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2025\$ 0b. FFY 2026\$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-E pages 1, 2, 3, 4, ~~5 (remove)~~, ~~6 (remove)~~8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable)Attachment 3.1-E pages 1 (TN#90-05), 2 (TN#90-05), 3  
(TN#90-05), 4 (TN#90-05)

Attachment 3.1-E Page 5

(remove)

Attachment 3.1-E Page 6 (remove)

9. SUBJECT OF AMENDMENT

Transplant Services Updates

10. 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

11. SIGNATURE OF STATE AGENCY OFFICIAL

 MD, MSc

12. TYPED NAME

Charissa Fotinos, MD, MSc

13. TITLE

Medicaid and Behavioral Health Medical Director

14. DATE SUBMITTED

October 24, 2024

15. RETURN TO

State Plan Coordinator

POB 42716

Olympia, WA 98504-2716

**FOR CMS USE ONLY**

16. DATE RECEIVED

October 24, 2024

17. DATE APPROVED

December 3, 2024

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL

January 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

 Digitally signed by James G. Scott -S  
Date: 2024.12.03 16:13:23 -06'00'

20. TYPED NAME OF APPROVING OFFICIAL

James G. Scott

21. TITLE OF APPROVING OFFICIAL

Director, Division of Program Operations

22. REMARKS

12/3/24: State authorizes the following pen and ink change:

-Box 7: Transfer deleted page requests from box 7 to box 8 for Attachment 3.1-E pages 5 and 6.

11/26/24: State authorizes the following pen and ink change:

-Box 5: Change to Section 1903(i) of the Act and 42 CFR 441.35

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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**STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES**

I. General Coverage Standards:

Transplant services, including inpatient and outpatient pre- and post-operative medical, surgical hospital, and related transportation services are covered for eligible beneficiaries when medically necessary.

A. The following standards apply to all transplant services:

1. The recipient must be enrolled with the state Medicaid program at the time the service is provided.
2. Similarly situated individuals are treated alike.
3. Services must be provided in a Medicare-approved transplant facility that is an enrolled provider with the Medicaid agency. For services provided in-state, the facility must also be approved by Washington's Department of Health Certificate of Need (CoN) program.
4. Transplants must be medically necessary and meet the requirements for physician and hospital services. Payment is rendered only for the transplants listed below, except for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population of Medicaid eligible children under the age of 21, for whom services are furnished based on medical necessity.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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**STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES**

- B. The following types of transplants and transplant-related procedures are covered, subject to the standards and criteria determined by the Organ Procurement and Transplantation Network (OPTN).
1. Bone Marrow
  2. Cornea
  3. Heart or combination heart-lung
  4. Intestine
  5. Kidney
  6. Liver or combination liver-kidney
  7. Lung single or bilateral
  8. Pancreas or combination pancreas- kidney
  9. Stem Cell, Autologous and Allogeneic
  10. Other transplants determined to be medically necessary and that meet the requirements for physician and hospital services.



## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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**STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES****II. Out-of-State Coverage Standards**

When services are available in-state, reimbursement will not be made to out-of-state transplant centers unless any of the conditions at [42 CFR 431.52\(b\)](#) are met and all other criteria for a transplant are met. Out-of-state centers will be considered if one of the following criteria exists:

1. The out-of-state hospital is compliant with [42 CFR 482.72 through 482.104](#)..
2. The type of transplant required is not available in-state or the type of transplant (e.g., liver transplant) is available in-state, but the in-state transplant center does not provide that type of transplant for all clients or for all covered diagnoses, (e.g., pediatric transplants)
3. An in-state transplant center requests the out-of-state transplant referral.
4. A contiguous out-of-state transplant center has a contract or special agreement with Washington.
5. It would be cost effective as determined by the agency. For example, if the transplant service is covered by the client's benefit package and the client's primary insurer (e.g., Medicare) requires the use of an out-of-state transplant center.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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**STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES**

III. Donor Services

The agency covers donor expenses incurred directly in connection with a covered transplant. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to the surgery.

IV. Limitations on Transplant Services

The agency limits identical organ transplant procedures to only once for the duration of the specific organ's established viability or as determined to be medically necessary. Requests for services in excess of limitations are evaluated for medical necessity on a case-by-case basis.

V. Non-Covered Transplant Services

The following types of transplants are not covered:

1. Transplants not listed in this state plan
2. Transplants that are considered experimental or investigational or which are performed on an experimental or investigational basis.