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State/Territory Name: WA

State Plan Amendment (SPA) #: 23-0041

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group/ Division of Reimbursement Review

October 11, 2023

Dr. Charissa Fotinos, Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 23-0041

Dear Director Fotinos:

We have reviewed the proposed Washington state plan amendment (SPA) to attachment 4.19-B of your state plan, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 20, 2023. This SPA updated rates and billing codes in alignment with the coding and coverage changes from the Centers for Medicare and Medicaid Services (CMS), the state, and other sources.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 11, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact DRR analyst James Moreth at James.Moreth@cms.hhs.gov or (206) 615-2043.

Sincerely,

[redacted]

Todd McMillion
Director

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0041

2. STATE: WA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XX

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 11, 2023

5. FEDERAL STATUTE/REGULATION CITATION
1902(a) of the social security act.

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 23 $ 0
b. FFY 2025 24 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B pages 5, 14, 16-3, 19, 20a, 21a
Supplement 3 to Attachment 4.19-B page 1

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B pages 5 (TN# 21-0033), 14 (TN# 23-0047), 16-3 (TN#23-0006), 19 (TN#23-0006), 20a (TN#21-0034), 21a (TN# 20-0034), Supplement 3 to Attachment 4.19-B page 1 (TN#22-0027)

9. SUBJECT OF AMENDMENT
July 2023 Fee Schedule Effective Date Update

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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Charissa Fotinos MD, MSc

13. TITLE
Medicaid and Behavioral Health Medical Director

14. DATE SUBMITTED
September 20, 2023

15. RETURN TO
State Plan Coordinator
628 8th Ave SE
Olympia, WA 98501

FOR CMS USE ONLY

16. DATE RECEIVED
9/20/23

17. DATE APPROVED
October 11, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/11/23

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

P&I change to box 5 to add "of the social security act".
P&I change to box 6 to correct FFYs to 2023 and 2024.

Instructions on Back

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, and effective April 1, 2014, the State anticipates that the managed care contractor will pay each clinic an encounter rate that is at least equal to the PPS rate specific to each clinic.

To ensure that the appropriate amounts are being paid to each clinic, the State will perform an analysis of the managed care contractor's data at least quarterly and verify that the payments made by the managed care contractor in the previous quarter were in compliance with Section 1902(bb)(5)(A) of the SSA. This process will apply to clinics reimbursed under the APM rate methodology and to clinics reimbursed under the PPS rate methodology.

At no time will a managed care organization be at risk for or have any claim to the supplemental payment portion of the rate which will be reconciled to ensure accurate payment of the obligated funds.

Covered services for Medicaid-Medicare patients are reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

Encounters are limited to one per client per day, except when:

- The client needs to be seen by different practitioners with different specialties; or
- The client needs to be seen multiple times on the same day due to unrelated diagnoses.

D. Non-hospital-owned Freestanding Ambulatory Surgery Centers

Freestanding ambulatory surgery centers (ASCs) are reimbursed in a manner similar to Medicare's ASC reimbursement model in effect prior to January 1, 2008. All ASC procedure codes are fit into one of nine payment groups, with each group having its own payment rate. New procedure codes are associated with the appropriate payment group based on their weights, which are set by CMS under its payment methodology in effect from January 1, 2008, forward. Any new procedure code is put into the payment group containing weights with which it is most similar. The agency pays for the first billed procedure code at 100%, the second at 50% and the third and subsequent procedure codes at zero.

Implantable devices are paid separately. For devices, the ASC bills the agency the amount the facility paid for the device, based on a manufacturer's invoice. The agency pays the invoiced amount.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The agency's rates were set as of July 11, 2023, and are effective for dates of services on and after that date.

See 4.19-B I, General #G, for the agency's website where the fee schedules are published.

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.)

VI. Dental Services and Dentures

A. The Medicaid agency pays directly to the specific provider the lesser of the usual and customary charge or a fee based on an agency fee schedule for dentures and dental services that are provided within their specific scope of practice by dentists, dental hygienists, denturists, and dental health aide therapists* (under supervision of a dentist within their scope of practice as defined under state law. The supervising licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner and the licensed practitioner bills for services furnished by unlicensed practitioners) throughout the state. There are no geographical or other variations in the fee schedule. **Technical correction: Dental health aide therapists added per SPA 17-0027 approved 6/21/2023 effective 7/23/2017*.

B. The usual and customary charge is defined as that fee usually charged for a given service by an individual dentist, dental hygienist, dental health aide therapist, or denturist to private patients (e.g., that provider's usual fee) and which fee is within the range of usual fees charged by dentists, dental hygienists, or denturists of similar training and experience.

C. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of dentures, dental services and dental hygiene.

See 4.19-B I, General, #G for the agency's website where the fee schedules are published.

The agency's fee schedule rate was set as of July 11, 2023, and is effective for services provided on or after that date.

D. Under the Oral Health Connections pilot program, eligible dental providers are paid an enhanced rate to provide up to three additional periodontal treatments (for a total of four) per calendar year to adult Medicaid clients who have diabetes or who are pregnant. The Oral Health Connections pilot program is effective for dates of service on or after January 1, 2019.

D. Eligible dental providers are paid an enhanced rate to provide additional dental services to eligible clients age 5 and under as described in Attachment 3.1-A and 3.1-B section 10.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

2. Fee Schedule

For non-CAH hospitals and covered services not paid using the OPPS or the “hospital outpatient rate”, the agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule for covered procedures.

Services paid using the agency’s fee schedule include, but are not limited to, physical therapy, occupational therapy, speech/language therapy, corneal transplants, and other hospital services as identified and published by the agency.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency’s outpatient fee schedule is effective for services provided on and after July 11, 2023. The fee schedule is updated quarterly in a budget neutral manner. See 4.19-B, I, General, #G for the agency’s website where the fee schedules are published.

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.)

IX. Other Noninstitutional Services

A. Home Health

1. Home Health Agencies are reimbursed per-visit for services provided by acute nursing staff, physical therapy, occupational therapy, speech, hearing and language disorders therapy staff, and home health aides.

   Reimbursement rates are determined using a historical base for the per-visit rates by profession, using the Medicare Metropolitan Statistical Area fees. Rate changes made through the Vendor Rate Increase (VRI) may be made only through the legislative process. Selected rates may also be adjusted through a special appropriation directed by the Washington State Legislature. The agency may set rates outside of the legislative process if the agency determines such actions are necessary to maintain access to critical services.

   The agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule for these services.

   Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The fee schedule is effective for services provided on and after July 11, 2023. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

2. Other Supplies and Services used in the home and other setting

   The agency's reimbursement rates include:
   a) Any adjustments or modifications to the equipment that are either required within three months of the delivery date, or are covered under the manufacturer's warranty
   b) Pick-up, delivery, or associated costs such as mileage, travel time, or gas
   c) Telephone calls
   d) Shipping, handling, and postage
   e) Fitting and setting up
   f) Maintenance of rented equipment
   g) Instructions to the client or client's caregiver about the safe and proper use of the equipment and supplies

   The equipment, supplies, and services for parenteral nutrition, home infusion therapy, oxygen, and respiratory care are reimbursed using the CMS DMEPOS Fee Schedule less a specified percentage. In April 2012, this specific percentage reduction was established at 3.5 percent as a result of a negotiated agreement with providers. For those items and services that are not listed on CMS DMEPOS Fee Schedule, the agency uses flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges).

   Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services and supplies. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

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.)

IX. C. Other Noninstitutional Services (cont.)

Eligible air ambulance providers will be cost reconciled to equal the cost of services provided during the fiscal period beginning July 1, 2010, through June 30, 2011, and for subsequent 12 month fiscal periods. Eligible providers are:

1. Operated by or affiliated with a public entity; and
2. "Major Air Ambulance Providers" whose service area covers all counties in the State of Washington. Cost will be determined by the Medicaid agency using a CMS-approved cost identification process in accordance with Medicare cost allocation principles. Cost for each Major Air Ambulance Provider will be identified and compared to the direct vendor payments based on fee-for-service. Based on this comparison, additional payment or recovery of payment will be made to assure that the total of payment equals cost.

(a) Annual Cost Report Process

During the state fiscal year, each Major Air Ambulance Provider must complete an annual Major Air Ambulance Provider cost report. The cost report will document the provider's total CMS-approved, Medicaid-allowable, direct and indirect costs of delivering Medicaid coverable services using a CMS-approved cost-allocation methodology. Reported personnel costs including wages, salaries, and fringe benefits must be exclusively attributable to air ambulance services provided. Total direct and indirect costs will be divided by the number of total transports to determine an average cost per trip. The average cost per trip will be multiplied by the number of paid Medicaid trips for the cost reporting year to determine Medicaid's allocable air ambulance costs.

(b) Cost Reconciliation Process

Annual direct vendor payments based on fee-for-service will be reconciled to total CMS-approved Medicaid-allowable costs calculated on page 20a section C(a). The total Medicaid-allowable scope of costs are compared to the direct vendor payments based on fee-for-service paid to the Major Air Ambulance Provider as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

(c) Cost Settlement Process

- Each Major Air Ambulance Provider will receive payments in an amount equal to the greater of (i) direct vendor payments based on fee-for-service, or (ii) total CMS-approved Medicaid-allowable costs for air ambulance services calculated in accordance with page 20a section C(a).
- If a Major Air Ambulance Provider's direct vendor payments based on fee-for-service exceed the provider's certified cost for air ambulance services provided to Medicaid clients, no cost settlement will be finalized and the direct vendor payments will be the final payments.
- If the certified cost of a Major Air Ambulance Provider exceeds the direct vendor payments based on fee-for-service, the Medicaid agency will pay the difference to the provider.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of air ambulance services. See 4.19-B, I. General #G for the agency's website where the rates are published. The Medicaid agency's fee schedule rate was set as of July 11, 2023, and is effective for services provided on or after that date.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

D. Rehabilitative Services

3. Behavioral Health Services (Substance Use Disorder (SUD) Services)

Payment for Substance Use Disorder (SUD) services provided in Medicaid Agency-approved behavioral health agencies is on a fee-for-service basis, with one day being the unit of service. The Medicaid Agency pays the lesser of the usual and customary charge or a fee based on an Agency fee schedule. The per diem rate on the Agency fee schedule for secure withdrawal management and stabilization is set at a flat fee based upon market value, other states' fees, and budget impacts.

There is no room and board paid for these services.

Payment for SUD services is provided to state-licensed behavioral health agencies on a fee-for-service basis for specific services. The Medicaid Agency pays the lesser of the usual and customary charge or a fee based on a Medicaid Agency fee schedule. There is no room and board paid for these services. Licensed SUD professionals who are paid by the facility, provide services

Except as otherwise noted in the plan, payment for these services is based on fee schedule rates, which are the same for both governmental and private providers of alcohol/drug treatment and detoxification services. The Agency's rates were set as of July 11, 2023 , and are effective for services rendered on or after that date. See 4.19-B I, General, #G, for the agency's website where the fee schedules are published.

A. Tribal Residential Substance Use Disorder Treatment Facilities

Payment to residential substance use disorder treatment facilities of the Indian Health Service (IHS), which includes, at the option of the tribe, residential substance use disorder treatment facilities operated by a tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act (also known as tribal residential substance use disorder treatment facilities), will be at a per patient, per day facility-specific rate for residential substance use disorder treatment services (including intensive residential treatment, withdrawal management, and recovery house services as applicable for the facility) for youth and adult patients, each rate negotiated with the respective tribe(s) or tribal organization for a base calendar year. During the negotiations, the state and the tribe or tribal organization may agree for the tribal facility to be responsible for the state share of financial participation in accordance with 42 C.F.R. § 433.51. The rate negotiated for a base calendar year will be adjusted annually thereafter, based on the percentage increase or decrease of the inpatient hospital per diem rate published each year in the Federal Register by the U.S. Department of Health and Human Services' Indian Health Service, under the authority of Sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. § 1601 et seq.).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

Conversion Factors

Maximum allowable fees are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). The MFSDB relative value units (RVU) are established by CMS, and have three components: work, practice expense, and malpractice. These RVUs are geographically adjusted (multiplied) each year by the statewide average geographic practice cost indices (GPCI) for Washington State, as published annually in the Federal Register. The adjusted RVUs are then multiplied by a service-specific conversion factor to derive a fee for each procedure.

Washington calculates the conversion factor through modeling. Modeling is the process of projecting fees into the coming year by using the previous full fiscal year's utilization data. The agency establishes budget neutrality each year when determining its conversion factors. If there is a mandate by the legislature, the conversion factor will then increase or decrease based on that mandate.

The agency has unique conversion factors for: adult primary health care, including E&M office visits; anesthesia services; children's primary health care services, including office visits and EPSDT screens; laboratory services; maternity services, including antepartum care, deliveries, and postpartum care; and all other services (e.g., radiological services, surgical services, consultations, etc.).

The programs listed in Attachment 4.19-B may fall into one or more categories of the conversion factors listed below, depending on the covered codes for that particular program. Each conversion factor category follows the corresponding sections of the CPT and HCPCS code books.

Conversion factors as of July 11, 2023:

Adult primary health: 14.87
Anesthesia services: 21.20
Children's primary health: 23.98
Laboratory services: 0.9708
Maternity services: 29.20
All other services: 18.98