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State/Territory Name: WA

State Plan Amendment (SPA) #: 22-0027

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
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601



Financial Management Group/ Division of Reimbursement Review

September 16, 2022

Susan Birch, Director
DR. Charissa Fotinos, Acting Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 22-0027

Dear Ms. Birch and Ms. Fontinos:

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 August 29, 2022. This SPA updated the fee schedule effective dates for several Medicaid programs and services. This is a regular, budget neutral update to keep 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. These changes are routine and do not reflect significant changes to policy or payment.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2022. 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,

Todd McMillion

Todd McMillion
Director

Enclosures

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

1. TRANSMITTAL NUMBER ____ _	2. STATE ____
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3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT
XIX XXI

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

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY _____ \$ _____
b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

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
Cherie Felt MD, MSc
12. TYPED NAME
13. TITLE
14. DATE SUBMITTED

15. RETURN TO

FOR CMS USE ONLY
16. DATE RECEIVED
17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED
18. EFFECTIVE DATE OF APPROVED MATERIAL
19. SIGNATURE OF APPROVING OFFICIAL
Todd McMillion
20. TYPED NAME OF APPROVING OFFICIAL
21. TITLE OF APPROVING OFFICIAL

22. REMARKS

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, and denturists throughout the state. There are no geographical or other variations in the fee schedule.
- B. The usual and customary charge is defined as that fee usually charged for a given service by an individual dentist, dental hygienist, 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 1, 2022, 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.

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

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.)

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

- iii. Uses the wage index information established and published by the Centers for Medicare and Medicaid Services (CMS) at the time the OPPS rates are set for the upcoming year. Wage index information reflects labor costs in the cost-based statistical area (CBSA) where a hospital is located.
- iv. Calculates the hospital-specific graduate medical education (GME) by dividing the direct GME cost reported on worksheet B, part 1, of the CMS cost report by the adjusted total costs from the CMS cost report.
- v. Uses the EAPG software to determine the following discounts:
 - Multiple Surgery/Significant Procedure – 50%
 - Bilateral Pricing – 150%
 - Repeat Ancillary Procedures – 50%
 - Terminated Procedures – 50%
- vi. Establishes a policy adjustor of 1.35 for services to clients age 17 and under, and establishes a policy adjustor of 1.10 for chemotherapy and combined chemotherapy/pharmacotherapy groups. These policy adjustors are not exclusive.

The statewide standardized conversion factor and all hospital-specific adjustments are effective July 1, 2022. See 4.19-B, I, General, #G for the agency's website where the fee schedule and conversion factors are published.

- c. Effective for dates of admission on or after July 1, 2013, supplemental payments will be paid for outpatient Medicaid services not to exceed the upper payment limit as determined by the available federal financial participation for fee-for-service claims. The supplemental payment is based on the distribution amount mandated by the legislature to the following hospital categories as defined in RCW 74.60.010:
 - Prospective Payment hospitals other than psychiatric or rehabilitation hospitals
 - Psychiatric hospitals
 - Rehabilitation hospitals
 - Border hospitals.

For hospitals designated as prospective payment system (PPS) hospitals, \$60,000,000 per state fiscal year. For hospitals designated as out-of-state border area hospitals, \$500,000 per state fiscal year.

The payment is calculated by applying the Medicaid fee-for-service rates in effect on July 1, 2009, to each hospital's Medicaid and CHIP outpatient fee-for-service claims and Medicaid and CHIP managed care encounter data for the base year as defined in RCW 74.60.010. This sum is divided by the aggregate total of all hospitals within each category to determine the individual hospital pro rata share percentage. The individual hospital payment is the pro rata percentage multiplied by the amount mandated to be distributed by the Legislature within each hospital category.

The payment will be made quarterly, by dividing the total annual disbursement amount by four (4) to calculate the quarterly amount.

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.)

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

2. Fee Schedule

For non-CAH hospitals and covered services not paid using the OPSS 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 1, 2022. 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

A. Outpatient hospital services (cont)

3. Hospital Outpatient Rate

The "hospital outpatient rate" is a hospital-specific rate having as its base the hospital's inpatient ratio of costs-to-charges (RCC) adjusted by an outpatient adjustment factor that factors annual cost and charge level changes into the rate. The "hospital outpatient rate" is used to reimburse under OPSS as explained earlier in this subsection, or for non-CAH hospitals exempt from the agency's OPSS, for all other covered outpatient services (those not mentioned in the previous paragraphs as covered by fee schedule) on the hospital's outpatient claim.

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 1, 2022. 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 Washington State Legislature approved a \$10.00 per hour rate increase for skilled nursing services provided in a home setting, effective for services provided on and after July 1, 2016.

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 1, 2022. 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

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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.)

X. All Other Practitioners

1. "All other practitioners" refers to other practitioners as described in section 6.d of Attachments 3.1-A and 3.1-B.
2. The agency pays the lesser of the usual and customary charge, or a fee based on an agency fee schedule.
3. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of services and the fee schedule and any annual/periodic adjustments to the fee schedule(s).
4. The facility fees used to calculate the payment rates for intensive behavior services (Applied Behavior Analysis (ABA) services) in facility settings will be calculated using methods that are consistent with Medicaid State Plan attachment 4.19-B sections II and VIII. A Outpatient hospital services. Outpatient hospitals and clinics rendering intensive behavior services as a day program do not receive a facility fee in addition to the per diem rate identified on the state's ABA Services fee schedule.

The agency's fee schedule rate was set as of July 1, 2022, and is effective for dates of services provided on or after that date. See 4.19-B, I. General #G for the agency's website where the fee schedules are published.
5. Collaborative care services are delivered under the Collaborative Care Model (CoCM). Payment rates for CoCM are based on the Medicare rates in effect on the date of service for Integrated Behavioral Health Services and are effective for dates of service on and after July 1, 2022.

Under CoCM, a medical care provider bills for the services provided by the collaborative care team. Only state-licensed physicians and state-licensed advanced registered nurse practitioners are eligible to be a medical care billing provider.
6. Community Assistance Referral and Education Services (CARES) programs include Treat and Refer services which are provided when clients' medical needs do not require ambulance transport to an emergency department. The rate was set as of July 1, 2019, and is effective for dates of services provided on or after that date. See 4.19-B, I. General #G for the agency's website where the rates are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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 1, 2022

Adult primary health: 15.32
Anesthesia services: 21.20
Children's primary health: 23.93
Laboratory services: 0.91
Maternity services: 28.72
All other services: 19.42