
Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 19-0012

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104



Western Division - Regional Operations Group

June 24, 2019

Susan Birch, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5502

RE: Washington State Plan Amendment (SPA) Transmittal Number 19-0012

Dear Ms. Birch and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the enclosed State Plan Amendment (SPA), Transmittal Number 19-0012. This amendment updated the fee schedule effective dates for several Medicaid programs and services.

This SPA is approved effective April 1, 2019. Enclosed is a copy of the CMS-179 summary form as well as the approved pages for incorporation into the State Plan.

If there are additional questions, please feel free to contact me or your staff may contact Julia Cantu at Julia.cantu@cms.hhs.gov or (206) 615-2339.

Sincerely,

Wendy Hill Petras
Acting Deputy Director

cc:
Ann Myers, SPA Coordinator

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
19-0012

2. STATE
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2019

5. TYPE OF PLAN MATERIAL (*Check One*):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2019 \$ 0
b. FFY 2020 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B pages 2, 5, 16-1, 16-3, 16-4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*)
Attachment 4.19-B pages 2, 5, 16-1, 16-3, 16-4

10. SUBJECT OF AMENDMENT

April 2019 Fee Schedule Effective Dates

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:

16. RETURN TO:

Ann Myers
Office of Rules and Publications
Division of Legal Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

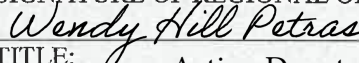
17. DATE RECEIVED: 6/3/19

18. DATE APPROVED: 6/24/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 4/1/19

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME: Wendy Hill Petras

22. TITLE: Acting Deputy Director

23. 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.)**

II. Clinic Services

- A. Unless otherwise specified in this section, Medicaid provider clinics are reimbursed at a fee-for-service rate established by the state. Specialized clinics are reimbursed only for services the clinic is approved to provide.
- B. Unless otherwise specified in this section, Medicaid provider clinics are reimbursed at a fee-for-service rate established by the state. Specialized clinics are reimbursed only for services the clinic is approved to provide.

Dialysis Services: Reimbursement for Hemodialysis, Intermittent Peritoneal Dialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD), and Continuous Cycling Peritoneal Dialysis (CCPD) is provided under a statewide composite rate. The composite rate includes all standard equipment, supplies, and services necessary for dialysis. Drugs covered on the Kidney Center Services fee schedule are paid according to Medicare's Average Sales Price (ASP) methodology. Payment limits on the drugs are updated quarterly based on the ASP pricing file located at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html?redirect=/McrPartBDrugAvgSalesPrice/>.

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

Dialysis services provided by freestanding facilities are clinic services and are reimbursed according to the provisions of 42 CFR 447.321.

- C. Rural Health Clinics
Effective January 1, 2001, the payment methodology for Rural Health Clinics (RHCs) conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Under BIPA 2000, all RHCs that provide services on or after January 1, 2001 and each succeeding year are reimbursed on a prospective payment system (PPS) or an accepted alternative methodology.

BIPA 2000 allows for payment to an RHC using an alternative methodology to the PPS, as long as the alternative methodology results in a payment to the clinic that is at least equal to the PPS payment rate.

This alternative methodology must be agreed to by the State and the RHC, and documentation of each clinic's agreement must be kept on file by the State. If an individual RHC does not agree to be reimbursed under this alternative methodology, the RHC will be paid under the BIPA PPS methodology.

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 April 1, 2019, 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

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 OPSS 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 April 1, 2019. 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

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 April 1, 2019. 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.

[Back to TOC](#)

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 April 1, 2019. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.