

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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



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**Financial Management Group**

September 30, 2020

Susan Birch, Director  
MaryAnne Lindeblad, Medicaid Director  
Health Care Authority  
PO Box 45502  
Olympia, WA 98504-5010

**RE: Washington State Plan Amendment (SPA) Transmittal Number 20-0024**

Dear Ms. Birch and Ms. Lindeblad:

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 10, 2020. This plan amendment updated several fee schedule effective dates and made a technical correction (name change) for a Medicaid program.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2020. We are enclosing the approved CMS-179 (HCFA-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](mailto:James.Moreth@cms.hhs.gov) or (206) 615-2043.

Sincerely,

*Todd McMillion*

Todd McMillion  
Director  
Division of Reimbursement Review

Enclosures



## 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 1, 2020, 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, 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, 2020, 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.

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VIII. Institutional Services

A. Outpatient hospital services

**Outpatient Prospective Payment System (OPPS)**

Duplicate payment for services does not occur. Non-Critical Access Hospital (CAH) outpatient hospital services are reimbursed using the Medicaid agency's Outpatient Prospective Payment System (OPPS). Under OPPS, services are reimbursed using one of the following payment methods:

- 1. Payment Grouping
  - a. Ambulatory Patient Classifications
  - b. Enhanced Ambulatory Patient Groups
  - c. Supplemental Payments
- 2. Fee schedule
- 3. Hospital Outpatient Rate

1. Payment Grouping

- a. For dates of service prior to July 1, 2014, the agency uses the Ambulatory Patient Classifications (APC) to classify OPPS services.

Effective for dates of service on or after July 1, 2013, payments for services reimbursed using the APC method at Prospective Payment System hospitals (as defined in Attachment 4.19-A, Part 1) will decrease by twenty-four and fifty-five hundredths percent (24.55%) from the rates that were established for dates of admission on and after July 7, 2011. This adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be four percent (4.00%) lower than the July 1, 2009, rates.

- b. Effective July 1, 2014, the agency uses the Enhanced Ambulatory Patient Groups (EAPG) to classify OPPS services. Under the EAPG system, the reimbursement of outpatient hospital services will include packaging of like services into groups with similar resource use.

For a significant procedure, the EAPG payment formula is as follows:

EAPG Relative Weight (RW) multiplied by the Hospital-Specific Conversion Factor multiplied by the Pricing Discount (if applicable) multiplied by the Policy Adjustor (if applicable)

To pay outpatient services under EAPG, the agency:

- i. Uses the national standard RWs developed by the 3M Corporation for determining relative resource intensity within the EAPG system. The relative weights are changed when grouper versions are changed. The relative weights effective July 1, 2020, are published on the agency's website. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.
- ii. Calculates a conversion factor for each hospital. Each conversion factor is based on a statewide standardized rate. The statewide standardized rate is determined at the time of rebasing as the maximum amount which can be used to ensure that aggregate outpatient reimbursement levels remain consistent. The statewide standardized rate is adjusted by a hospital-specific wage index and medical education component. See 4.19-B, I, General #G for the website where the fee schedules are published.

The formula for determining a hospital's specific conversion factor is: Statewide Standardized Rate x ((0.6 x WageIndex) + 0.4) / (1 - (DMECost/TotalCost))-

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## 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 July 1, 2020. 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.

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## 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 1, 2020. 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.

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## 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, 2020. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.



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## 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, 2020. 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.

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## IX. Other Noninstitutional Services (cont.)

- B. The Medicaid agency makes payment for transportation to and from medically necessary services covered by a client's medical assistance program as specifically listed below.
1. Ambulance services for emergency situations are paid as an optional medical service through direct vendor payments based on fee-for-service.
  2. All non-emergency transportation services, to assure clients have access to and from covered services, are provided using either administrative matched dollars or medical match dollars in accordance with Section 42 CFR 431.53 and Attachment 3.1-C.
    1. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of transportation services. The agency's fee schedule rate was set as of July 1, 2020, and is effective for 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.
    4. In the case of a governor-declared state of emergency and when the agency determines it is appropriate, the agency may elect to make supplemental payments for transportation services provided in connection with the emergency.

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## D. Rehabilitative Services

## 3. Alcohol/Drug Treatment and Detoxification Services

Payment for detoxification services provided in freestanding Medicaid Agency-approved alcohol/drug treatment centers 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 alcohol/drug treatment services is provided to certified facilities on a fee-for-services 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 chemical dependency 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 1, 2020, 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.

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## IX. Other Noninstitutional Services (cont.)

## I. Private Duty Nursing Services

Private duty nursing services consist of four or more hours of continuous skilled nursing services provided in the home to eligible clients who are 17 years of age or younger with complex medical needs that cannot be managed within the scope of intermittent home health services. The agency will authorize private duty nursing services up to a maximum of 16 hours per day, restricted to the least costly, equally effective amount of care. Nursing rates for services provided in the home setting are flat rates and based on comparable nursing rates.

Rate changes made through the Vendor Rate Increase (VRI) may be made only through the legislative process. Selected rate changes 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% rate increase to the hourly rate and the daily rate for skilled nursing services provided in a home setting, effective for services provided on and after January 1, 2020.

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, 2020. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

## J. Physical therapy, occupational therapy, and services for Individuals with speech, hearing and language disorders

The agency does not pay separately for therapy services that are included as part of payment for other treatments or programs.

The Medicaid Agency pays the lesser of the usual and customary charge or a fee based on a Medicaid Agency fee schedule for these services. Maximum allowable fees are developed using the Resource Based Relative Value Scale (RBRVS) methodology. Rates are established and updated using the RBRVS methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code, chapter 182-531, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factors and descriptions are found in Supplement 3 to Attachment 4.19-B.

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## 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, 2020, 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 2016 Medicare rates for Integrated Behavioral Health Services and are effective for dates of service on and after July 4, 2018.

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.

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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 (MFSDDB). The MFSDDB 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, 2020:

Adult primary health: 18.61

Anesthesia services: 21.2

Children's primary health: 27.93

Laboratory services: 0.92

Maternity services: 32.4

All other services: 20.0