

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

March 31, 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 20-0005

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 February 20, 2020. This plan amendment updated the fee schedule effective dates for several Medicaid programs and services.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 1, 2020. 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
Acting Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 20-0005	2. STATE Washington
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE January 1, 2020	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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: 1902(a) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY 2020 \$0 b. FFY 2021 \$0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B pages 5, 14, 16-1, 16-3, 16-4 Attachment 4.19-B page 25, 32	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B pages 5, 14, 16-1, 16-3, 16-4 Attachment 4.19-b page 25, 32

10. SUBJECT OF AMENDMENT:

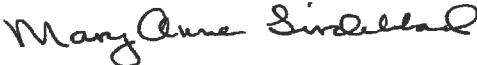
January Fee Schedule Effective Dates

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Exempt

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

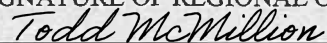
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Ann Myers Rules and Publications Division of Legal Services Health Care Authority 626 8 th Ave SE MS: 42716 Olympia, WA 98504-2716
13. TYPED NAME: MaryAnne Lindeblad	
14. TITLE: Director	
15. DATE SUBMITTED: 2-20-2020	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 03/31/2020
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PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/2020	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Todd McMillion	22. TITLE: Acting Director, Division of Reimbursement Review

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 (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 January 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.

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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 January 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, through December 31, 2021.
- 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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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 January 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.

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 January 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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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 January 1, 2020. 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.)

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 January 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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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.)

XV. Personal Care Services (cont)

B. Service Rates

The fee schedule was set as of January 1, 2020, to be effective for dates of service on and after January 1, 2020.

Effective Jan. 1, 2008, the standard hourly rate for individual-provided personal care is based on comparable service units and is determined by the State legislature, based on negotiations between the Governor's Office and the union representing the workers. The rate for personal care services provided by individual providers consists of wages, industrial insurance, paid time off, mileage reimbursement, comprehensive medical, training, seniority pay, training based differentials, and other such benefits needed to ensure a stable, high performing workforce. The agreed-upon negotiated rates schedule is used for all bargaining members.

The rate for personal care services provided by agencies is based on an hourly unit. The agency rate determination corresponds to the rate for individual providers with an additional amount for employer functions performed by the agency.

The rate for personal care provided in assisted living facilities is based on a per day unit. Each participant is assigned to a classification group based on the State's assessment of their personal care needs. The daily rate varies depending on the individual's classification group. The rates are based on components for provider staff, operations, and capital costs. The rate paid to residential providers does not include room and board.

The rate for personal care provided in an adult family home is based on a per day unit and is determined by the State legislature, based on negotiations between the Governor's Office and the union representing Adult Family Homes.

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