DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355 (300)
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 3, 2024

Susan Birch, Director
Dr. Charissa Fotinos, State Medicaid Director
Washington State Health Care Authority
Post Office Box 45502
Olympia, WA 98504-5010

Re: Washington State Plan Amendment (SPA) – 24-0041

Dear Director Birch and Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0041. This amendment will revise out-of-date transplant coverage policies to conform to industry standards and government practices to the Medicaid State Plan.

We conducted our review of your submittal according to statutory requirements in Section 1903(i) of the Act and 42 CFR 441.35. This letter informs you that Washington State Plan Amendment (SPA) – 24-0041 was approved on December 3, 2024, with an effective date of January 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Washington State Plan.

If you have any questions, please contact Edwin Walaszek at (212)-616-2512 or via email at edwin.walaszek1@cms.hhs.gov.

Sincerely,

Digitally signed by James G. Scott -S
Date: 2024.12.03 16:12:16 -06'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Ann Myers, Section Manager & State Plan Coordinator, Health Care Authority

DEPARTMENT OF HEALTH AND HUMAN 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: 24 — 0041

2. STATE: WA

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
January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
~~1902a of the Social Security Act, 42 CFR parts 121 and 482~~
Section 1903(i) of the Act and 42 CFR 441.35

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-E pages 1, 2, 3, 4, ~~5 (remove), 6 (remove)~~

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-E pages 1 (TN#90-05), 2 (TN#90-05), 3 (TN#90-05), 4 (TN#90-05)
Attachment 3.1- E Page 5 (remove)
Attachment 3.1-E Page 6 (remove)

9. SUBJECT OF AMENDMENT
Transplant Services Updates

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
Charissa Fotinos MD, MSc

12. TYPED NAME
Charissa Fotinos, MD, MSc

13. TITLE
Medicaid and Behavioral Health Medical Director

14. DATE SUBMITTED
October 24, 2024

15. RETURN TO
State Plan Coordinator
POB 42716
Olympia, WA 98504-2716

FOR CMS USE ONLY

16. DATE RECEIVED
October 24, 2024

17. DATE APPROVED
December 3, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
James G. Scott
Digitally signed by James G. Scott -S
Date: 2024.12.03 16:13:23 -06'00'

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

12/3/24: State authorizes the following pen and ink change:

-Box 7: Transfer deleted page requests from box 7 to box 8 for Attachment 3.1-E pages 5 and 6.

11/26/24: State authorizes the following pen and ink change:

-Box 5: Change to Section 1903(i) of the Act and 42 CFR 441.35

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

I. General Coverage Standards:

Transplant services, including inpatient and outpatient pre- and post-operative medical, surgical hospital, and related transportation services are covered for eligible beneficiaries when medically necessary.

A. The following standards apply to all transplant services:

1. The recipient must be enrolled with the state Medicaid program at the time the service is provided.

2. Similarly situated individuals are treated alike.

3. Services must be provided in a Medicare-approved transplant facility that is an enrolled provider with the Medicaid agency. For services provided in-state, the facility must also be approved by Washington's Department of Health Certificate of Need (CoN) program.

4. Transplants must be medically necessary and meet the requirements for physician and hospital services. Payment is rendered only for the transplants listed below, except for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population of Medicaid eligible children under the age of 21, for whom services are furnished based on medical necessity.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

B. The following types of transplants and transplant-related procedures are covered, subject to the standards and criteria determined by the Organ Procurement and Transplantation Network (OPTN).

1. Bone Marrow
2. Cornea
3. Heart or combination heart-lung
4. Intestine
5. Kidney
6. Liver or combination liver-kidney
7. Lung single or bilateral
8. Pancreas or combination pancreas- kidney
9. Stem Cell, Autologous and Allogeneic
10. Other transplants determined to be medically necessary and that meet the requirements for physician and hospital services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

II. Out-of-State Coverage Standards

When services are available in-state, reimbursement will not be made to out-of-state transplant centers unless any of the conditions at 42 CFR 431.52(b) are met and all other criteria for a transplant are met. Out-of-state centers will be considered if one of the following criteria exists:

1. The out-of-state hospital is compliant with 42 CFR 482.72 through 482.104..

2. The type of transplant required is not available in-state or the type of transplant (e.g., liver transplant) is available in-state, but the in-state transplant center does not provide that type of transplant for all clients or for all covered diagnoses, (e.g., pediatric transplants)

3. An in-state transplant center requests the out-of-state transplant referral.

4. A contiguous out-of-state transplant center has a contract or special agreement with Washington.

5. It would be cost effective as determined by the agency. For example, if the transplant service is covered by the client's benefit package and the client's primary insurer (e.g., Medicare) requires the use of an out-of-state transplant center.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

III. Donor Services

The agency covers donor expenses incurred directly in connection with a covered transplant. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to the surgery.

IV. Limitations on Transplant Services

The agency limits identical organ transplant procedures to only once for the duration of the specific organ's established viability or as determined to be medically necessary. Requests for services in excess of limitations are evaluated for medical necessity on a case-by-case basis.

V. Non-Covered Transplant Services

The following types of transplants are not covered:

1. Transplants not listed in this state plan

2. Transplants that are considered experimental or investigational or which are performed on an experimental or investigational basis.