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State/Territory Name: WA

State Plan Amendment (SPA) #: 24-0049

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

December 17, 2024

Charissa Fotinos, Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: TN 24-0049

Dear director Fotinos:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Washington state plan amendment (SPA) to Attachment 4.19-B WA 24-0049, which was submitted to CMS on November 26, 2024. This plan amendment updated the fee schedule effective dates for several Medicaid programs and services.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of October 1, 2024. 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 (206) 615-2043 or via email at James.Moreth@CMS.HHS.GOV.

Sincerely,

Todd McMillion

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN 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 — 0049

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
October 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
1905a of the Social Security Act

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 4.19-B pages 5, 14, 16, 16-1, 16-3, 16-4, 23a, 30

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B pages 5 (TN# 24-0022), 14 (TN# 24-0022), 16 (TN# 24-0022), 16-1 (TN# 24-0022), 16-3 (TN# 24-0022), 16-4 (TN# 24-0021), 23a (TN# 23-0049), 30 (TN# 16-0009)

9. SUBJECT OF AMENDMENT
October 2024 Fee Schedule Effective Date 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
November 26, 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
11/26/24

17. DATE APPROVED
December 17, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
10/1/24

19. SIGNATURE OF APPROVING OFFICIAL
Todd McMillion

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, DRR

22. REMARKS

12/6/24- P&I change to box 7 to add pages 23a and 30.

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 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 October 1, 2024, 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

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, denturists, and dental health aide therapists* (under supervision of a dentist within their scope of practice as defined under state law. The supervising licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner and the licensed practitioner bills for services furnished by unlicensed practitioners) throughout the state. There are no geographical or other variations in the fee schedule. **Technical correction: Dental health aide therapists added per SPA 17-0027 approved 6/21/2023 effective 7/23/2017*.

B. The usual and customary charge is defined as that fee usually charged for a given service by an individual dentist, dental hygienist, dental health aide therapist, 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 October 1, 2024, 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. This pilot program ended on December 31, 2023.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

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

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 October 1, 2024, 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))

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 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 October 1, 2024. 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 January 1, 2024, 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:

- 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 to each hospital's Medicaid and CHIP outpatient fee-for-service claims and Medicaid and CHIP managed care encounter data for the base year. 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 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 October 1, 2024. 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 OPPS as explained earlier in this subsection, or for non-CAH hospitals exempt from the agency’s OPPS, 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 October 1, 2024. 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 (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 October 1, 2024. 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, 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.

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.)

XIV. Hospice Services

A. Payment for hospice services is made to a designated hospice provider using the CMS annually published Medicaid hospice rates that are effective from October 1 of each year through Sept. 30 of the following year. With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at one of the following four pre-determined daily rates. The rates are contingent on the type of service provided that day. The rates are based on the Medicaid guidelines and are wage adjusted. The Medicaid agency uses the Hospice Wage Index published by CMS. The pre-determined daily rates are:

1. Routine Home Care (RHC): Hospice providers are paid one of two levels of RHC for dates of service on and after January 1, 2016. This two-rate payment methodology will result in a higher RHC rate based on payment for days one (1) through sixty (60) of hospice care and a lower RHC rate for days sixty-one (61) or later. A minimum of sixty (60) day's gap in hospice services is required to reset the counter that determines which payment category a participant is qualified for.

2. Continuous Home Care (CHC)

3. Inpatient Respite Care (IRC)

4. General inpatient hospice care

B. Service Intensity Add-On

Effective for hospice services with dates of service on and after October 1, 2024 , hospice services are eligible for an end-of-life service intensity add-on payment when the following criteria are met:

1. The day on which the services are provided is an RHC level of care;
2. The day on which the service is provided occurs during the last seven days of life, and the client is discharged deceased;
3. The service is provided by a registered nurse or social worker that day for at least fifteen minutes and up to four hours total; and
4. The service is not provided by the social worker via telephone.

C. Hospice Care Furnished to an Individual In a Nursing Facility

The agency pays a hospice nursing facility room and board if the client is admitted to a nursing facility or a hospice care center and is not receiving general inpatient care or inpatient respite care. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility), must equal at least 95% of the per diem rate that DSHS would have paid to the nursing facility for that individual in that facility under the State Plan.

The room and board rates are set by the Department of Social and Health Services (DSHS) and published on the DSHS website at https://www.dshs.wa.gov/altsa/management-services-division/nursing-facility-rates-and-reports