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State/Territory Name: Washington

State Plan Amendment (SPA) #: 19-0029

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages
December 13, 2019

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 19-0029

Dear Ms. Birch and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number WA 19-0029. This amendment was submitted to update the fee schedule effective dates for several Medicaid programs and services.

This SPA is approved with an effective date of October 1, 2019.

If there are additional questions, please contact me or your staff may contact James Moreth at James.Moreth@cms.hhs.gov or (206) 615-2043.

Sincerely,

David L. Meacham
Associate Regional Administrator

cc:
Ann Myers, SPA Coordinator
## TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

### FOR: HEALTH CARE FINANCING ADMINISTRATION

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

### TRANSMITTAL NUMBER:
19-0029

### STATE:
Washington

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

### PROPOSED EFFECTIVE DATE:
October 1, 2019

### TYPE OF PLAN MATERIAL (Check One):

- [ ] NEW STATE PLAN
- [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN
- [X] AMENDMENT

### FEDERAL STATUTE/REGULATION CITATION:
1902(a) of the Social Security Act

### FEDERAL BUDGET IMPACT:
- a. FFY 2020 $0
- b. FFY 2021 $0

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

### PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):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

### SUBJECT OF AMENDMENT:
October Fee Schedule Effective Dates

### 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
- [X] OTHER, AS SPECIFIED: Exempt

### SIGNATURE OF STATE AGENCY OFFICIAL:
[Redacted]

### TITLE:
Mary Anne Lindeblad

### DATE SUBMITTED:
12-6-19

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

### DATE RECEIVED:
12/6/19

### DATE APPROVED:
12/13/19

### EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/19

### SIGNATURE:
[Redacted]

### TITLE:
Deputy Director

### REMARKS:
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, 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.
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, 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.
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 October 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
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, 2019. See 4.19-B, I, General, #G for the agency’s website where the fee schedules are published.