

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

January 18, 2022

Susan Birch, Director
DR. Charissa Fotinos, Acting Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 21-0034

Dear Ms. Birch and Ms. Fontinos:

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 November 17, 2021. This plan amendment updated the fee schedule effective dates for several Medicaid programs and services. This was a regular, budget neutral update to keep rates and billing codes in alignment with the coding and coverage changes from the Centers for Medicare and Medicaid Services (CMS), the state, and other sources.

Based upon the information provided by the state, we have approved the amendment with an effective date of October 1, 2021. 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
Director
Division of Reimbursement Review

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
21-0034

2. STATE
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

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

4. PROPOSED EFFECTIVE DATE
October 1, 2021

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 2022 \$0
b. FFY 2023 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B pages 5, 16-1, 16-3, 16-4, 20, 20a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B pages 5, 16-1, 16-3, 16-4, 20, 20a

10. SUBJECT OF AMENDMENT:

October 2021 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:

Charissa Fotinos MD, MSc

16. RETURN TO:

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

13. TYPED NAME:

Charissa Fotinos, MD, MSc

14. TITLE:

Acting Medicaid Director

15. DATE SUBMITTED:

11/17/2021

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
November 17, 2021

18. DATE APPROVED:
January 18, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:

Todd McMillion

21. TYPED NAME:

Todd McMillion

22. TITLE:

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 October 1, 2021, 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

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 October 1, 2021. 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 October 1, 2021. 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, 2021. 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.)

- 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 October 1, 2021, 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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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. C. Other Noninstitutional Services (cont.)

Eligible air ambulance providers will be cost reconciled to equal the cost of services provided during the fiscal period beginning July 1, 2010 through June 30, 2011, and for subsequent 12 month fiscal periods. Eligible providers are:

1. Operated by or affiliated with a public entity; and
2. "Major Air Ambulance Providers" whose service area covers all counties in the State of Washington. Cost will be determined by the Medicaid agency using a CMS-approved cost identification process in accordance with Medicare cost allocation principles. Cost for each Major Air Ambulance Provider will be identified and compared to the direct vendor payments based on fee-for-service. Based on this comparison, additional payment or recovery of payment will be made to assure that the total of payment equals cost.

(a) Annual Cost Report Process

During the state fiscal year, each Major Air Ambulance Provider must complete an annual Major Air Ambulance Provider cost report. The cost report will document the provider's total CMS-approved, Medicaid-allowable, direct and indirect costs of delivering Medicaid coverable services using a CMS-approved cost-allocation methodology. Reported personnel costs including wages, salaries, and fringe benefits must be exclusively attributable to air ambulance services provided. Total direct and indirect costs will be divided by the number of total transports to determine an average cost per trip. The average cost per trip will be multiplied by the number of paid Medicaid trips for the cost reporting year to determine Medicaid's allocable air ambulance costs.

(b) Cost Reconciliation Process

Annual direct vendor payments based on fee-for-service will be reconciled to total CMS-approved Medicaid-allowable costs calculated on page 20a section C(a). The total Medicaid-allowable scope of costs are compared to the direct vendor payments based on fee-for-service paid to the Major Air Ambulance Provider as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

(c) Cost Settlement Process

- Each Major Air Ambulance Provider will receive payments in an amount equal to the greater of (i) direct vendor payments based on fee-for-service, or (ii) total CMS-approved Medicaid-allowable costs for air ambulance services calculated in accordance with page 20a section C(a).
- If a Major Air Ambulance Provider's direct vendor payments based on fee-for-service exceed the provider's certified cost for air ambulance services provided to Medicaid clients, no cost settlement will be finalized and the direct vendor payments will be the final payments.
- If the certified cost of a Major Air Ambulance Provider exceeds the direct vendor payments based on fee-for-service, the Medicaid agency will pay the difference to the provider.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of air ambulance services. The fee schedule and any annual/periodic adjustments to the fee schedule are published at <http://hrsa.dshs.wa.gov/rbrvs/>. The Medicaid agency's fee schedule rate was set as of October 1, 2021, and is effective for services provided on or after that date.