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State/Territory Name: Washington

State Plan Amendment (SPA) #: 24-0006

This file contains the following documents in the order listed:

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

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

Medicaid and CHIP Operations Group

March 1, 2024

Susan Birch, HCA Director and Interim Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

Re: Washington State Plan Amendment (SPA) 24-0006

Dear Director Birch:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0006. This amendment proposes to increase the total compensated amount on all claim types to $250.00 in accordance with Title 42, Chapter IV, Subchapter C, Part 433 of the Code of Federal Regulations.

We conducted our review of your submittal according to statutory requirements in 1902a of the Social Security Act, 42 CFR Part IV Sub C Sect 433. This letter is to inform you that Washington Medicaid SPA 24-0006 was approved on March 1, 2024, with an effective date of January 1, 2024.

If you have any questions, please contact Edwin Walaszek at 212-616-2512 or via email at Edwin.Walaszek1@cms.hhs.gov

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2024.03.01 12:30:30 -06'00'

James G. Scott, Director
Division of Program Operations

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 — 0006

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, 2024

5. FEDERAL STATUTE/REGULATION CITATION
1902a of the Social Security Act 42 CFR Part IV Sub C Sect 433

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 0
b. FFY ~~2925~~ 2025 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.22-B page 2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.22-B page 2 (TN# 20-0017)

9. SUBJECT OF AMENDMENT
Third Party Liability 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
[redacted]

12. TYPED NAME
Susan E. Birch, MBA, BSN, RN

13. TITLE
Director and Acting Medicaid Director

14. DATE SUBMITTED
February 20, 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
February 20, 2024

17. DATE APPROVED
March 1, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2024.03.01 12:30:56 -06'00'

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

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

22. REMARKS

2/27/24:State authorizes the following pen and ink changes:
-Box 6.B: Change 2925 to 2025

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Requirement for Third Party Liability – Payment of Claims

1. The method to determine compliance with requirements of Section 433.139(b)(3)(ii)(c) is as follows: The State Plan as referenced herein requires providers to bill third parties. In a case where medical support is being enforced by the state Title IV-D Agency, the provider will be required to submit written documentation that he has billed the third party and has not received payment from the third party. It must be at least 100 days from the date of service before the state will pay.

   The Medicaid agency pays for medical services and seeks reimbursement from a liable third party when the claim is for preventive pediatric services as covered under the early and periodic screening, diagnosis, and treatment (EPSDT) program contained in Section 433.139(b)(3)(i). If the preventive pediatric service is identified in the MMIS as cost-avoidance based on cost-effectiveness or access to care, section 53102(a)(1) of the Bipartisan Budget Act of 2018 warrants cost-avoidance for 90 days.

   State laws are in effect that require third parties to comply with the provisions of 1902(a)(25)(I) of the Social Security Act, including those which require third parties to provide the state with coverage, eligibility, and claims data.

2. Claims for medical services, unless identified under existing state regulations regarding recovery of Agency-paid claims from clients' primary insurance carriers, are cost-avoided when a third party liability (TPL) policy exists within the MMIS (the state's Medicaid payment system known as ProviderOne) that matches the benefit coverage-type and service date. Claims paid by the Agency prior to the TPL policy being entered into the MMIS are pursued for recovery through an invoice submitted to the primary insurance carrier. The cost-effectiveness threshold to pursue recovery on a health insurance claim is monitored by the MMIS and invoices claims to the primary carrier if the total claim paid amount is $15.00 or more.

   Generally, casualty insurance claims are pursued for recovery. Paid claims related to an accident/Injury on a Medicaid client are manually reviewed. The cumulative paid amount on the claim(s) must exceed $ 250.00 to open a casualty case file on the injured client. Additionally, MMIS automatically reviews the paid amount on an accident- or injury-related claim and initiates a Treatment Questionnaire (TQ) letter to the client if the total claim payment is $ 250.00 or more.

3. The agency will seek recovery from the third party within 60 days after the end of the month in which payment was made. This does not apply to exceptions for Good Cause or Confidential Services cases. Good Cause and Confidential Services cases include Title IV-D domestic violence cases and certain clients with STD/HIV, pregnancy, or abortion-related services/diagnosis. The agency will also seek recovery within 60 days of the date the agency learns of the existence of a third party or when benefits become available. Claims identified under 4.22-B page 1 (1.) should follow the specified 90 to 100 day waiting period before initiating recovery.

4. When the Agency has determined a sum certain receivable amount has been validated and the third party fails to make payment, after 90 days the Agency refers the case to the Department of Social and Health Services' Office of Financial Recovery for formal collection activities. These