DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

August 19, 2026

Ms. Trinity Wilson, Medicaid and CHIP Director
Washington State Health Care Authority
628 8th Avenue
PO Box 45502
Olympia, WA 98504-5050

Dear Ms. Wilson:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Washington's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on October 2, 2025, and a final revised preprint was received on June 24, 2026. The proposal has a control name of WA_Fee_IPH.OPH2_Renewal_20260101-20261231.

CMS has completed our review of the following Medicaid managed care SDP(s):

- The uniform dollar increases established by the state for inpatient hospital services provided by eligible Critical Access Hospitals and Prospective Payment System Hospitals and the uniform percentage increases established by the state for outpatient hospital services provided by eligible Critical Access Hospitals and Prospective Payment System Hospitals for the rating period January 1, 2026 through December 31, 2026, incorporated in the capitation rates through a separate payment term up to $2.003 billion.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other

modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

Based on CMS's preliminary determination, the SDP proposal with the control name of WA_Fee_IPH.OPH2_Renewal_20250101-20251231 likely qualified for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of $2.003 billion for the grandfathered SDP named WA_Fee_IPH.OPH2_Renewal_20250101-20251231 submitted on September 30, 2024 (as specified in item 4 of the applicable SDP preprint form) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

CMS is approving this preprint with the following condition of concurrence: Effective with the State rating period beginning on or after July 9, 2027, the State will be required to comply with 42 CFR § 438.6(c)(2)(iv)(C) and establish a performance target that demonstrates improvement over the baseline statistic for at least one performance measure in the SDP evaluation plan. CMS strongly encourages the State to seek technical assistance in advance of the State's CY 2028 SDP renewal submission to ensure compliance with this regulatory requirement. Please contact the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov for technical assistance.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.08.19 12:07:21 -04'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   January 1, 2026 - December 31, 2026
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* January 1, 2026
3. Identify the managed care program(s) to which this payment arrangement will apply:
   The directed payments will apply to the Apple Health Fully Integrated Managed Care and Apple Health Foster Care managed care programs.
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: Approximately $2.003 billion net of the 2.09% managed care plan premium tax
   a. Identify the estimated federal share of this state directed payment: $1.398 billion
   b. Identify the estimated non-federal share of this state directed payment: $0.605 billion

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

2024

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☒ Quality Metric(s) / Benchmark(s) Change
☒ Other; please describe:

Estimated payments

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

To estimate ACR we applied commercial pay-to-charge ratios (sourced from Milliman's CY 2024 CHSD source data, without trending) to projected/trended Medicaid billed charges. Key components of this calculation are described as follows:

Commercial allowed-to-charge ratios were based on Washington hospital commercial payer claims experience for inpatient and outpatient hospital services incurred from January 1, 2024 through December 31, 2024 (CY 2024) from the CHSD data, without trending, aggregated at the service line and Washington State metropolitan statistical area (MSA) level (including "non-MSA" rural areas). These commercial pay-to-charge ratios were cross-walked to the Medicaid charges based on hospital location and service line. For a limited number of cases where the combination of an MSA and service line commercial pay-to-charge ratio was not available, we applied commercial pay-to-charge ratios based on the service line statewide average.

Projected Medicaid billed charges were based on Washington Medicaid managed care encounter data for inpatient and outpatient hospital services with dates of services from CY 2024, trended using CMS market basket to 2026. The Washington Medicaid managed care encounter data was processed through the Milliman Health Cost Guidelines™ (HCG) Grouper to assign a service line, consolidate interim claims, and validate the completeness and validity of relevant data fields. Billed charge trend was based on changes in CMS market basket index levels from the midpoint of CY 2024 base data to the CY 2026 rating period. Exclusions were applied to restrict the data to Medicaid managed care utilization that would be eligible for directed payments (e.g., removal of Medicare crossover claims).

The ACR per unit amounts were calculated at the aggregate hospital provider class level based on aggregate estimated payments under ACR divided by aggregate Medicaid utilization (days for inpatient and visits for outpatient).

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

Medicaid State Plan:
https://www.hca.wa.gov/assets/program/SP_Att_4_PaymentforServices.pdf

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

• PPS hospitals, inpatient per discharge add-on, excluding normal newborns: $13,125. The estimated directed outpatient uniform percent increase (applied to Medicaid managed care plan base claim payments) for each class are as follows: • PPS ho

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

As described previously, hospitals will receive interim lump-sum quarterly payments from MCOs as directed by HCA, based on utlization from a period 9 months prior. After the end of contract year, HCA will conduct a reconciliation process based on actual contract year utilization and will direct the MCOs to make payment adjustments. See our response to question 8 on details of the payment methodology.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The directed payment program provides additional funding to hospitals to address workforce challenges and recent cost pressures, while achieving HCA's stated goals and objectives as described in Table 7 of this preprint.

As described previously, the prospective UPIs were developed based on the grandfathered CY 2025 directed payment pools, which HCA determined is reasonable and appropriate for the classes of providers to further the state's quality goals (described in later sections) and to ensure access to essential hospital services. As shown in Table 2, total Medicaid managed care payments are less than 100% of ACR for each setting, provider class, and program cohort.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☒ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☒ behavioral health inpatient services
- ☒ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

There are two provider classes described in the table below:

Hospital Class Hospital Reimbursement Class Qualifications
Critical Access Hospitals (CAH) Based on in-state hospitals that meet the Medicare CAH designation and are approved by the Washington State Department of Health as a CAH. This provider type is recognized in Washington's Medicaid State Plan in Attachment 4.19-B page 18 and in the Revised Code of Washington (RCW) 74.09.5225.

PPS Hospitals Based on in-state "Prospective Payment System" (PPS) hospitals reimbursed for Medicaid inpatient and outpatient services under the inpatient prospective payment system and the outpatient prospective payment system as recognized in the Washington Medicaid State Plan Attachment 4.19-A page 30a and in the Washington Administrative Code (WAC) 182-550-1050. This provider class does not include hospitals participating in the certified public expenditure program or any hospital owned by a health maintenance organization.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Both provider classes are consistent with provider type definitions approved in the Washington State Plan and promulgated in Washington State regulations:

• The Washington State Medicaid State Plan Attachment 4 can be found below:
https://www.hca.wa.gov/assets/program/SP_Att_4_PaymentforServices.pdf

• Revised Code of Washington (RCW) rural hospital definition can be found below:
https://app.leg.wa.gov/rcw/default.aspx?cite=74.09.5225

• Washington State Administrative Code (WAC) PPS hospital definition can be found below:
https://app.leg.wa.gov/wac/default.aspx?cite=182-550-1050

• Directed payment provider class definitions per legislation passed by Washington state legislature:
https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1850-S.SL.pdf

Intergovernmental transfers (IGTs) are not relied upon to finance the inpatient or outpatient directed payments for these hospital types.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The inpatient directed payments are based on a per discharge uniform dollar amount specific to each hospital class. The outpatient directed payments are based on a uniform percentage increase specific to each hospital class. HCA will require that MCOs provide the same uniform dollar amounts and percentage increases by class for inpatient and outpatient hospital services to hospitals which meet the established eligibility qualifications outlined in question 20b.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☒

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a.					
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: Average Commercial Rates

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

To estimate ACR we applied commercial pay-to-charge ratios (sourced from Milliman's CY 2024 CHSD source data, without trending) to projected, trended Medicaid billed charges. Key components of this calculation are described as follows:

Commercial allowed-to-charge ratios were based on Washington hospital commercial payer claims experience for inpatient and outpatient hospital services incurred from January 1, 2024 through December 31, 2024 (CY 2024) from the CHSD data, without trending aggregated at the service line and Washington State metropolitan statistical area (MSA) level (including "non-MSA" rural areas). These commercial pay-to-charge ratios were cross-walked to the Medicaid charges based on hospital location and service line. For a limited number of cases where the combination of an MSA and service line commercial pay-to-charge ratio was not available, we applied commercial pay-to-charge ratios based on the service line statewide average.

Projected Medicaid billed charges were based on Washington Medicaid managed care encounter data for inpatient and outpatient hospital services with dates of services from CY 2024. The Washington Medicaid managed care encounter data was processed through the Milliman Health Cost Guidelines™ (HCG) Grouper to assign a service line, consolidate interim claims, and validate the completeness and validity of relevant data fields. Billed charge trend was based on changes in CMS market basket index levels from the midpoint of CY 2024 base data to the CY 2026 rating period. Exclusions were applied to restrict the data to Medicaid managed care utilization that would be eligible for directed payments (e.g., removal of Medicare crossover claims).

Base payments are based on the same period with a trending factor.

The ACR per unit amounts were calculated at the aggregate hospital provider class level based on aggregate estimated payments under ACR divided by aggregate Medicaid utilization (days for inpatient and visits for outpatient).

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As mentioned, the proposed uniform increases result in Medicaid managed care payments that are below 100% of payments estimated under commercial reimbursement. HCA has determined that ensuring that rates are commensurate with commercial payment rates will help promote access and equity, and supply the resources these hospitals need to provide high quality care, while establishing reimbursement levels that remain within the 100% ACR limit for the provider class

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

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b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. MCR-WA-004-AHIMC	10/03/2025	Yes	116
ii. MCR-WA-005-IFC	10/17/2025	Yes	81
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

N/A

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

HCA believes a separate payment term is appropriate to ensure adequate precision in the distribution of the interim directed payments. Continued implementation of the proposed directed payments as a separate payment term results in administrative efficiencies for all parties involved in the directed payment arrangement. Without the use of a separate payment term, additional administrative burdens would exist, such as the need for an additional quarterly reconciliation process to monitor and ensure that the aggregate interim directed payments made to hospitals are consistent with the target quarterly aggregate directed payment amounts. HCA believes its proposed annual reconciliation process already accomplishes the appropriate allocation of the directed payments across hospitals based on actual contract year utilization.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ☐ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☒ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. . Hospital Safety Net Program (HSNP)– inpatient	Inpatient hospital services	No	No	Yes		No
ii. Hospital Safety Net Program (HSNP) – outpatient	Outpatient hospital services	No	No	Yes		No
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. Hospital Safety Net Tax Waiver Outpatient		Approved	06/14/2024
ii. Hospital Safety Net Tax Waiver Inpatient		Approved	06/14/2024
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.hca.wa.gov/assets/program/13-0053-washington-state-managed-care-quality-strategy.pdf
- **b.** The effective date of quality strategy. November 1, 2025

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Aim 2: Assure enrollees have timely access to care.	2.2 Ensure access to care for members receiving services to treat mental health conditions	12
b. Aim 2: Assure enrollees have timely access to care	2.3 Ensure access to care for members receiving services to treat substance use disorders.	12
c. Aim 3: Assure medically necessary services are provided to enrollees as contracted	3.2: Ensure that MCOs appropriately utilize care coordination and care management services to meet each enrollee's needs.	13
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

This payment arrangement supports PPS hospitals in maintaining their role as core safety net providers, ensuring access to critical inpatient and outpatient services for members with mental health conditions and substance use disorders. By strengthening these hospitals, the arrangement also enhances care coordination across settings so that enrollee needs are met through timely and continuous services

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Low-Risk Cesarean Delivery (LRCD), Total; NQF # N/A	CY 2022	23.3%	23.3%	
ii. Follow-Up After Hospitalization for Mental Illness (FUH), Total - 30 days; NQF # 0576	CY 2023	64.6%	64.6%	
iii. Plan All-Cause Readmissions (PCR), Total; NQF # 1768, (observed-to-expected ratio)	CY 2023	0.98	.98	PCR O/E ratio baselines will be re-based each year to reflect the most current methodology and ensure valid year-over-year comparisons
iv. Follow –Up After Emergency Department Visit for Substance Use (FUA), Total - 30 days; NQF # N/A	CY 2023	34.6%	34.6	

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

See attached evaluation report

PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 2. in the preprint, please delete Tabs 1.A and 3.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 2.A: Provider Payment Analyses

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	**Free text**	**Percent (#.##%)**	**Percent (#.##%)**	**Percent (#.##%) or N/A**	**Percent (#.##%) or N/A**	**Percent (#.##%)**
Example:	*Rural Inpatient Hospital Services*	*80.0%*	*20.0%*	*N/A*	*N/A*	*100.0%*
a.	CAH Outpatient – Integrated Managed Care	72.6%	21.5%	0.0%	N/A	94.1%
b.	CAH Outpatient – Integrated Foster Care	56.8%	16.8%	0.0%	N/A	73.6%
c.	PPS Inpatient – Integrated Managed Care	46.0%	41.1%	0.0%	N/A	87.2%
d.	PPS Inpatient – Integrated Foster Care	57.2%	34.9%	0.0%	N/A	92.1%
e.	PPS Outpatient – Integrated Managed Care	22.2%	28.1%	0.0%	N/A	50.3%
f.	PPS Outpatient – Integrated Foster Care	18.7%	23.7%	0.0%	N/A	42.4%
g.						
h.						

State Directed Payment Evaluation Findings Template

As indicated in the preprint, states must “describe prior year(s) evaluation findings and the payment arrangement’s impact on the goal(s) and objective(s) in the states quality strategy” in “any year other than Year 1 of a multi-year effort.” By providing evaluation data for each year of the payment arrangement, states will be able to understand the impact of the payment arrangement over time.

States may use the tables below to provide evaluation findings in their renewal preprints. The **tables are optional** but encompass CMS’ expectations for what states include when sharing evaluation findings and describing their evaluation methodology.

Table 1. Washington ’s Evaluation Findings for WA_Fee_IPH.OPH2 , Contract Rating Years 2024-2027

Metric Name	Baseline Year	Baseline Statistic	Performance Target	Evaluation Data									
				20 21 – 20 21	20 22 – 20 22	20 23 – 20 23	20 24 – 20 24	20 – 20	20 – 20	20 – 20	20 – 20	20 – 20	20 – 20
FUH - 30 day, total (statewide)	CY2023	64.6%	≥ 64.6%	67.2% (54.5%)	65.2% (58.5%)	64.9% (58.7%)	66.0% (NA)						
LRCD (statewide)	CY2022	23.3%	≤ 23.3%	22.7% (22.2%)	23.3% (22.5%)	24.7% (23.5%)	24.9% (23.8%)						
PCR - O/E (statewide)	CY2023	0.98	≤ 0.98	NA (0.9)	0.97 (0.9)	0.98 (0.9)	1.02 (NA)						
FUA - 30 day, total (statewide)	CY2023	34.6%	≥ 34.6%	39.5% (NA)	30.9% (43.8%	35.1% (38.8%)	37.6% (NA)						

Table 2. Washington 's Evaluation for WA_Fee_IPH.OPH2

Prompt	*Response*
Evaluation metrics	
Please share the data source(s) and year(s) of data used to calculate the evaluation metrics.	The evaluation metrics are calculated using validated claims data from providers participating in the directed payment. The data source is the Medicaid claims system, and results are based on trends using the most recent complete years of data.
Please confirm that the data used to calculate the evaluation metrics was limited to Medicaid managed care enrollees.	Yes
Please confirm that the data used to calculate the evaluation metrics was limited to providers participating in the payment arrangement.	Yes, the MY 2026 evaluation plan has been updated to use data limited to participating providers, which resulted in changes to the baselines and targets from the previous submissions
Evaluation methodology	
Please identify the entity conducting the evaluation.	Washington Health Care Authority, the state's medicaid agency, with RN
Please describe the analytic methods used to understand the impact of the payment arrangement. For example, comparison groups, pre-post study design, etc.	Analytic methods will include a pre/post trend analysis to assess performance relative to the established baseline, supplemented by comparisons to statewide rates to provide additional context for evaluating impact
Please share any limitations of the state's evaluation plan.	A key limitation in evaluating the impact of the directed payment is the difficulty in isolating its specific effects from other influences on provider performance. Because the evaluation relies on a pre/post trend analysis and comparisons to statewide performance, results may reflect factors beyond the payment

Prompt	***Response***
Findings	
Please share the state's assessment of the impact of this payment arrangement.	The payment arrangement for PPS, psychiatric, rehabilitation, and critical access hospitals continues to show areas of progress alongside opportunities for further improvement. FUH 30-day follow-up rates remain above the established baseline, with performance improving to 66.0% in 2024 compared to a baseline of 64.6%, and consistently exceeding statewide managed care performance, which has remained below 60%. FUA 30-day follow-up also shows improvement from the 2022 low point, with 2024 results at 37.6%, exceeding the baseline target of 34.6%. These outcomes demonstrate the provider group's ability to sustain performance above statewide averages in key behavioral health continuity measures.
Please share any relevant context (e.g., changes to the managed care program) that may have impacted the evaluation results	Larger contextual factors exist (e.g., lessening impacts during post-COVID-19 timeframe, transitions of care quality initiatives); however, none were specifically identified as directly impacting this SDP
For all evaluation metrics that did not improve over baseline, please share any plans the state has to address declining performance.	The state's first priority was to select quality measures that are meaningful, reflect identified gaps in care, and align with existing state priorities, while designing data calculations specifically for the targeted provider group to ensure performance is accurately captured. 2024 has been a significant building year for the state's SDP quality program, focused on creating sustainable plans that meet the requirements of the Managed Care Final Rule and lay the groundwork for long-term improvement. Efforts include aligning measures across provider types for collective impact to improve client transitions of care, engaging providers and advocacy groups to strengthen collaboration and support effective implementation, and updating MCO contracts to formally incorporate SDP quality activities into annual QAPI