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State/Territory Name: Washington

State Plan Amendment (SPA) # WA 25-0032

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

March 12, 2026

Trinity Wilson
Medicaid Director Health Care Authority
PO Box 45502
Olympia, WA 98504-5010
RE: TN 25-0032

Dear Acting Director Wilson:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Washington state plan amendment (SPA) to Attachment 4.19-A, WA 25-0032, which was submitted to CMS on December 16, 2025 . This plan amendment updates the cost report numbering from the previous version throughout the CPE protocol section of the state plan.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 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 January 1, 2026 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 Tom Caughey at 517-487-8598 or via email at tom.caughey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

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: 25-0032

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, 2026

5. FEDERAL STATUTE/REGULATION CITATION
1905(a) of the Social Security Act; 42 CFR art 440

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 0
b. FFY 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 3 to Attachment 4.19-A Part I pages 2 - 5

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 3 to Attachment 4.19-A Part 1 pages 2 (TN 07-007), 3 (TN 07-007), 4 (TN 07-007), 5 (TN 07-007)

9. SUBJECT OF AMENDMENT
Update Certified Public Expenditure Protocol

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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Trinity Wilson

13. TITLE
Interim Medicaid Director

14. DATE SUBMITTED
December 15, 2025

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

FOR CMS USE ONLY

16. DATE RECEIVED
December 16, 2025

17. DATE APPROVED
March 12, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2026

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

CPE Protocol (cont)

NOTES:

(i) For purposes of utilizing the Medicare 2552 cost report to determine Medicaid reimbursements described in the subsequent instructions, the following terms are defined:

The term "finalized" refers to the cost report that is settled by the Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement.

The term "filed" refers to the cost report that is submitted by the hospital to the Medicare fiscal intermediary and is normally due 5 months after the end of the cost reporting period.

Any revision to the finalized Medicare 2552cost report as a result of Medicare appeals or reopening will be incorporated into the final determination.

Certified Public Expenditures – Determination of Allowable Medicaid Hospital Costs

Interim Medicaid Inpatient Hospital Payment Rate

The purpose of an interim Medicaid inpatient hospital payment rate is to provide an interim payment that will approximate the Medicaid inpatient hospital costs eligible for participation claimed through the CPE process. This computation of establishing interim Medicaid inpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

1. The process of determining the allowable Medicaid inpatient hospital costs eligible for FFP begins with the use of each governmentally-operated hospital's most recently filed Medicare 2552 cost report.

2. To determine the interim Medicaid payment rate, the State should use the most recently filed Medicare 2552 cost report and determine an overall Ratio of Costs to Charges (RCC) rate for routine and ancillary services.

The specifics follow, effective on or after January 1, 2026:
:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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CPE Protocol (cont)

DETERMINE RCC COSTS – FIRST STEP

Step 1: Compute costs by using Worksheet C, Part 1 – Computation of Costs to Charges, Column 5

a) Plus, line 202, subtotal
b) Minus, line 44-45, nursing facility costs
c) Minus, line 101, home health
d) Minus line 116, hospice
e) Minus, line 88, rural health center costs
f) Minus, line 89, federally qualified health center costs
g)
h) Minus any other costs related to non-hospital service cost centers included in line 202 above
i) Plus, wks B, Part 1, Col. 25, line 118 direct medical education costs

Result = Total Adjusted RCC Costs

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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CPE Protocol (cont)

RCC CHARGES – STEP TWO

Step 2: Compute charges by using Worksheet C, Part 1, Computation of Costs to Charges

a) Plus, line 202, col. 8 total charges
b) Minus, lines 44-45, nursing facility charges
c) Minus, lines 88, rural health center charges
d) Minus, lines 89, federally qualified health center charges
e) Minus, line 101, Home Health
f) Minus, line 116, Hospice
g)
h) Minus any other charges related to non-hospital service cost centers included in line 202 above

Result = Total Adjusted Charges

Step 3: Divide Total Adjusted Cost by Total Adjusted Charges

RESULT OF STEP 3 IS THE HOSPITAL'S Ratio of Cost to Charges (RCC)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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CPE Protocol (cont)

The RCC rate calculated above is then applied to Title XIX inpatient claims, including Rehabilitation and Psychiatric claims, as they are submitted by the hospitals for payment. The cost for the claim is determined by multiplying the covered charges by the RCC rate. Third party and client responsibility payments are deducted from the cost to determine the reimbursement amount. The reimbursement amount is then paid to the hospital for the claim.

Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Each governmentally-operated hospital's interim payments will be reconciled to its Medicare 2552cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period.

The State will adjust the cost used in the Worksheet C computation of each cost center's cost-to-charge ratio by adding back allowable interns and residents costs to the appropriate cost centers.

An updated RCC will be calculated based on the as filed cost report using the same methodology described on pages 2 and 3 of this protocol. The updated RCC will be applied to the service year covered Title XIX inpatient fee-for-service charges in the MMIS system to calculate costs incurred during the service year. Third party and client responsibility payments are deducted from the cost to determine the certifiable amount. The Department will compare the Medicaid CPEs as calculated from the as filed CMS 2552 cost report. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Each governmentally-operated hospital's interim payments and interim adjustments will also be subsequently reconciled to its Medicare 2552 cost report as finalized by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period.

The State will adjust the cost used in the Worksheet C computation of each cost center's cost-to-charge ratio by adding back allowable interns and residents costs to the appropriate cost centers.

The hospitals will use CMS 2552 Worksheet D series or substitute CMS-approved schedules that mirror the Worksheet D series to arrive at Title XIX inpatient hospital cost. Worksheet D series include 1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient hospital days for that cost center to the per diem amount; 2) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid inpatient hospital charges for each ancillary cost center; 3) computing organ-specific costs per organ and