

## **Table of Contents**

**State/Territory Name: Washington**

**State Plan Amendment (SPA) #: 26-0001**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
601 E. 12th St., Room 355  
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

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June 23, 2026

Ryan Moran, Director  
Trinity Wilson, State Medicaid Director  
Washington State Health Care Authority  
Post Office Box 45502  
Olympia, WA 98504-5010

Re: Washington State Plan Amendment (SPA) – 26-0001

Dear Director's Moran and Wilson:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 26-0001. This amendment proposes updates to Third Party Liability protocol to align how the agency administers other third-party liability requirements for Medicaid as the payer of last resort with respect to the WA Cares program and carceral reentry.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR §433.139. This letter informs you that Washington's Medicaid SPA TN WA-26-0001 is approved on June 23, 2026, with an effective date of July 1, 2026.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Washington State Plan.

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

Sincerely,

Nicole McKnight  
Acting Director, Division of Program Operations

Enclosures

cc: Jason McGill, Assistant Director, Washington State Health Care Authority  
Ann Myers, Section Manager & State Plan Coordinator, Washington State Health Care Authority

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 6 — 0 0 0 1</u>	2. STATE <u>WA</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
July 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION  
42 CFR 433.139

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  
Attachment 4.22-B pages 1, 2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  
~~Attachment 4.22-B pages 1 (TN 24-0006), 2 (TN 20-0017)~~  
Attachment 4.22-B pages 1 (TN 20-0017), 2 (TN 24-0006)

9. SUBJECT OF AMENDMENT

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

CY OFFICIAL

13. TITLE  
Medicaid Director

14. DATE SUBMITTED  
April 28, 2026

15. RETURN TO

**FOR CMS USE ONLY**

16. DATE RECEIVED  
April 28, 2026

17. DATE APPROVED  
June 23 2026

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL  
July 1, 2026

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

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

22. REMARKS

4/29/26: State authorizes the following pen and ink change:

- Box 8: • Change the superseded TN for page 1 to TN 20-0017 and for page 2 change to TN 24-0006.

## 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)(B) 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 the third party has been billed and has not received payment from the third party. It must be within 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.
 

Claims are cost-avoided for clients who have long-term care (LTC) benefits with a commercial TPL or are active beneficiaries under the Washington Cares Fund Program (WA Cares) when their available WA Cares benefit balance is \$250.00 or greater.

Claims are cost-avoided for incarcerated clients receiving care outside a carceral facility from inpatient or community providers, such as community pharmacy or provider visits. Due to the Medicare suspension policy and the low occurrence of incarcerated clients having private health insurance coverage, the Agency will not apply coordination of benefits (COB) cost-avoidance claim rules by having the MMIS bypass all COB claim edits for care occurring within or by a carceral facility. The Agency will annually monitor the occurrence of incarcerated clients reporting other health insurance.

In the instance that the agency or its contracted plans discover a paid claim has TPL, the agency will seek to recover payment from the liable third party via post pay recovery. The mechanisms in place will track whether or not exceptions ever materialize. The agency will seek reimbursement within sixty days from the end of the month in which the agency learns of the existence of the liable third party.

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.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## REQUIREMENT FOR THIRD PARTY LIABILITY - PAYMENT OF CLAIMS (cont.)

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 include skip tracing, payment demands, negotiating debts and repayment agreements, and enforcement action, including legal action. "Sum certain receivable" is when a liable third party (regardless of the third party resource type) and predetermined settlement or recovery has been validated through either court settlement or explanation of benefits (EOBs) and remittance advices (RAs). Claims identified under 4.22-B page 1 (1.) should follow the specified 90 to 100 day waiting period before initiating a referral.
5. For Casualty recoveries, the agency complies with 42 U.S.C. §1396a (a) (25) (B) and uses the following factors and guidelines in determining whether to pursue recovery of benefit, after deduction of the agency's proportionate share of attorney's fee and cost, from a liable party.
  - A. Ascertain the amount of Medicaid lien and the amount of the gross settlement.
  - B. Determine whether the Medicaid lien plus attorney's fees and costs will exhaust or exceed the settlement funds.
  - C. If the answer to B is Yes; and if the agency:
    - a. Is informed the client will not pursue the claim; or
    - b. Cannot handle the case, once it is tendered to the agency by the client or the client's attorney to pursue on behalf of the client; or
    - c. Made reasonable effort to ascertain the client's intention regarding the claim, but could not obtain a response;
 Then the agency follows the procedures stated in D.
  - D. The agency considers the cost effectiveness principle in determining what is the estimated net recovery amount of be pursued, based on the likelihood of collections. Net recovery amount is defined as that amount of recovered dollars to apply to Medicaid costs. In determining the estimated recovery amount, the following factors are considered:
    - a. Settlement as may be affected by insurance coverage or other factors relating to the liable party;
    - b. Factual and legal issues of liability as may exist between the client and liable party;
    - c. Problems of proof faced in obtaining the award or settlement; and
    - d. The estimated attorney's fee and costs required for the Agency to pursue the claim.
  - E. After considering the above factors, the agency may pursue a lesser recovery amount to the extent that the agency determines it to be cost-effective to do so.