

Table of Contents

State/Territory Name: WA

State Plan Amendment (SPA) #: 26-0002

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
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604



Financial Management Group

April 21, 2026

Trinity Wilson, Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: TN 26-0002

Dear Director Wilson,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Washington state plan amendment (SPA) to Attachment 4.19-B WA 26-0002, which was submitted to update the Fee Schedule effective dates of several Medicaid services.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 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 DRR analyst James Moreth at (206) 615-2043 or via email at James.Moreth@CMS.HHS.GOV.

Sincerely,

A solid black rectangular box redacting the signature of Todd McMillion.

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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

1. TRANSMITTAL NUMBER 2 6 — 0 0 0 2 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
Section 1902(a) of the Social Security Act

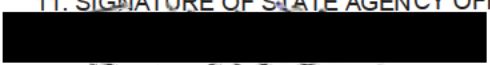
6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 \$ 0
b. FFY 2027 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B pages 14, 16, 25, 28a

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 4.19-B pages 14(TN 25-0020), 16 (TN 24-0014), 25 (TN 25-0020), 28a (TN 15-0034)

9. SUBJECT OF AMENDMENT
January 2026 Fee Schedule Effective Date 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


12. TYPED NAME
Trinity Wilson

13. TITLE
Interim Medicaid Director

14. DATE SUBMITTED
February 2, 2026

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


FOR CMS USE ONLY

16. DATE RECEIVED
2/2/26

17. DATE APPROVED
April 21, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
1/1/26

19. SIGNATURE OF APPROVING OFFICIAL


20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, DRR

22. 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**

VI. Dental Services and Dentures

- A. The Medicaid agency pays directly to the specific provider the lesser of the usual and customary charge or a fee based on an agency fee schedule for dentures and dental services that are provided within their specific scope of practice by dentists, dental hygienists, denturists, and dental health aide therapists* (under supervision of a dentist within their scope of practice as defined under state law. The supervising licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner and the licensed practitioner bills for services furnished by unlicensed practitioners) throughout the state. There are no geographical or other variations in the fee schedule. **Technical correction: Dental health aide therapists added per SPA 17-0027 approved 6/21/2023 effective 7/23/2017.*
- B. The usual and customary charge is defined as that fee usually charged for a given service by an individual dentist, dental hygienist, dental health aide therapist, or denturist to private patients (e.g., that provider's usual fee) and which fee is within the range of usual fees charged by dentists, dental hygienists, or denturists of similar training and experience.
- C. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of dentures, dental services and dental hygiene.
- See 4.19-B I, General, #G for the agency's website where the fee schedules are published.
- The agency's fee schedule rate was set as of January 1, 2026, and is effective for services provided on or after that date.
- D. Under the Oral Health Connections pilot program, eligible dental providers are paid an enhanced rate to provide up to three additional periodontal treatments (for a total of four) per calendar year to adult Medicaid clients who have diabetes or who are pregnant. The Oral Health Connections pilot program is effective for dates of service on or after January 1, 2019. This pilot program ended on December 31, 2023.
- D. Eligible dental providers are paid an enhanced rate to provide additional dental services to eligible clients age 5 and under as described in Attachment 3.1-A and 3.1-B section 10.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

VIII. Institutional Services

A. Outpatient hospital services

Outpatient Prospective Payment System (OPPS)

Duplicate payment for services does not occur. Non-Critical Access Hospital (CAH) outpatient hospital services are reimbursed using the Medicaid agency's Outpatient Prospective Payment System (OPPS). Under OPPS, services are reimbursed using one of the following payment methods:

1. Payment Grouping
 - a. Ambulatory Patient Classifications
 - b. Enhanced Ambulatory Patient Groups
 - c. Supplemental Payments
2. Fee schedule

1. Payment Grouping

- a. For dates of service prior to July 1, 2014, the agency uses the Ambulatory Patient Classifications (APC) to classify OPPS services.

Effective for dates of service on or after July 1, 2013, payments for services reimbursed using the APC method at Prospective Payment System hospitals (as defined in Attachment 4.19-A, Part 1) will decrease by twenty-four and fifty-five hundredths percent (24.55%) from the rates that were established for dates of admission on and after July 7, 2011. This adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be four percent (4.00%) lower than the July 1, 2009, rates.

- b. Effective July 1, 2014, the agency uses the Enhanced Ambulatory Patient Groups (EAPG) to classify OPPS services. Under the EAPG system, the reimbursement of outpatient hospital services will include packaging of like services into groups with similar resource use.

For a significant procedure, the EAPG payment formula is as follows:

EAPG Relative Weight (RW) multiplied by the Hospital-Specific Conversion Factor multiplied by the Pricing Discount (if applicable) multiplied by the Policy Adjustor (if applicable)

To pay outpatient services under EAPG, the agency:

- i. Uses the national standard RWs developed by the 3M Corporation for determining relative resource intensity within the EAPG system. The relative weights are changed when grouper versions are changed. The relative weights effective January 1, 2026, are published on the agency's website. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.
- ii. Calculates a conversion factor for each hospital. Each conversion factor is based on a statewide standardized rate. The statewide standardized rate is determined at the time of rebasing as the maximum amount which can be used to ensure that aggregate outpatient reimbursement levels remain consistent. The statewide standardized rate is adjusted by a hospital-specific wage index and medical education component. See 4.19-B, I, General #G for the website where the fee schedules are published.

The formula for determining a hospital's specific conversion factor is: $\text{Statewide Standardized Rate} \times ((0.6 \times \text{WageIndex}) + 0.4) / (1 - (\text{DMECost}/\text{TotalCost}))$

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.)

X. All Other Practitioners

1. "All other practitioners" refers to other practitioners as described in section 6.d of Attachments 3.1-A and 3.1-B.
2. The agency pays the lesser of the usual and customary charge, or a fee based on an agency fee schedule.
3. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of services and the fee schedule and any annual/periodic adjustments to the fee schedule(s).
4. The facility fees used to calculate the payment rates for intensive behavior services (Applied Behavior Analysis (ABA) services) in facility settings will be calculated using methods that are consistent with Medicaid State Plan attachment 4.19-B sections II and VIII. A Outpatient hospital services. Outpatient hospitals and clinics rendering intensive behavior services as a day program do not receive a facility fee in addition to the per diem rate identified on the state's ABA Services fee schedule.

The agency's fee schedule rate was set as of January 1, 2026, and is effective for dates of 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.

5. Collaborative care services are delivered under the Collaborative Care Model (CoCM). Payment rates for CoCM are based on the 2016 Medicare rates for Integrated 25 Services and are effective for dates of service on and after July 4, 2018.

Under CoCM, a medical care provider bills for the services provided by the collaborative care team. Only state-licensed physicians and state-licensed advanced registered nurse practitioners are eligible to be a medical care billing provider.

6. Community Assistance Referral and Education Services (CARES) programs include Treat and Refer services which are provided when clients' medical needs do not require ambulance transport to an emergency department. The rate was set as of July 1, 2019, and is effective for dates of services provided on or after that date. See 4.19-B, I. General #G for the agency's website where the rates are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

XIII. Targeted Case Management Services (cont)

B. Infant Case Management (ICM)

The agency provides infant case management services to Medicaid infants and their parent(s) for the direct benefit of the eligible infant from the time the infant is three months of age through the month of the infant's first birthday.

For the purpose of this program, the State defines a parent(s) as a person who resides with an infant, provides the day-to-day care, is authorized to make health care decisions, and is:

The infant's natural or adoptive parent(s);

A person other than a foster parent who has been granted legal custody of the infant; or

A person who is legally obligated to support the infant.

Payment for Title XIX targeted case management services may not duplicate payments made to public agencies or private entities under other programs for this same purpose. If the eligible infant and family are involved in services for another targeted group, ICM is closed and case management for the other targeted group is initiated.

Targeted case management for ICM is billed on a per-visit basis, with each visit based on time increments of 15 minutes equaling one unit. Unit limitations are described in agency billing instructions.

Computation of the per-unit rate takes the following into consideration:

- Relative value of targeted case management services provided by similar professionals in different settings;
- Historical expenditures for ICM services; and
- Other expenses related to provision of targeted case management services (e.g., travel time and associated travel costs, charting/documentation time, etc.)

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 case management fee was set as of January 1, 2026, and is effective for dates of service on and after that date. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.