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State/Territory Name: Washington

State Plan Amendment (SPA) #: 26-0010

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

September 9, 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) – 26-0010

Dear Directors Moran and Wilson:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 26-0010. This amendment removes an outdated reference to Attachment 4.19-E in the numbered pages section of the Medicaid State Plan.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR § 447.45. This letter informs you that Washington's Medicaid SPA TN 26-0010 was approved on September 9, 2026, with an effective date of May 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.

Sincerely,

[redacted]

Megan K. Buck
Director, Division of Program Operations

Enclosures

cc: Ann Myers
Jason McGill

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: 26 — 0010

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
May 1, ~~2027~~ 2026

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR ~~433.139~~ 447.45

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY ~~2027~~ 2026 $ 0
b. FFY ~~2028~~ 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Numbered Pages page 61

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Numbered Pages page 61 (TN 78-18)

9. SUBJECT OF AMENDMENT
Remove Outdated 4.19-E Reference

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
Trinity Wilson

13. TITLE
Medicaid and CHIP Director

14. DATE SUBMITTED
June 25, 2026

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

FOR CMS USE ONLY

16. DATE RECEIVED
June 25, 2026

17. DATE APPROVED
September 9, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
May 1, 2026

19. SIGNATURE OF APPROVING OF
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Megan K. Buck

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

22. REMARKS

9/4/26-State authorizes the following pen and ink change:

Box 4: Change to '2026'
Box 5: Change to '42 CFR 447.45'
Box 6a: Change to '2026'
Box 6b: Change to '2027'

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CFR 447.45 (c) AT-79-50	4.19 (e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.