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

October 24, 2022

Susan Birch, Director
Dr. Charissa Fotinos, Acting Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, WA 98504-5010

Re: Washington State Plan Amendment (SPA) 22-0020

Dear Director Birch and Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) completed review of Washington's State Plan Amendment (SPA) Transmittal Number 22-0020 submitted on September 6, 2022. The purpose of this SPA is to increase the Personal Needs Allowance (PNA) for all Medicaid in-home clients, including PACE enrollees, from 100 percent of the Federal Poverty Level to 300 percent of the Federal Benefit Rate.

We conducted our review of this amendment according to statutory requirements of Title XIX of the Social Security Act and implementing Federal regulations. This letter is to inform you that Washington's Medicaid SPA Transmittal Number 22-0020 is approved effective July 1, 2022.

If you have any questions regarding this amendment, please contact Claudia Simonson at (312) 353-2115 or via email at claudia.simonson@cms.hhs.gov.

Sincerely,

Bill Brooks
Director
Division of Managed Care Operations

cc: Cindy Proper, CMCS
Kelli Emans
Lori Rolley
Katheryn Pittelkau

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: 22 — 0020

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
July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
1905(a) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 7,284
b. FFY 2023 $ 100,012

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 3 to Attachment 3.1-A pages 2, 4

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 3 to Attachment 3.1-A pages 2, 4

9. SUBJECT OF AMENDMENT
PACE 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
Charissa Fotinos MD, MSc

12. TYPED NAME
Charissa Fotinos, MD, MSc

13. TITLE
Medicaid and Behavioral Health Medical Director

14. DATE SUBMITTED
September 6, 2022

15. RETURN TO
State Plan Coordinator
Office of Rules & Publications
Health Care Authority
POB 42716
Olympia, WA 98504

FOR CMS USE ONLY

16. DATE RECEIVED
9/6/22

17. DATE APPROVED
10/24/22

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/22

19. SIGNATURE OF APPROVING OFFICIAL
Bill Brooks

20. TYPED NAME OF APPROVING OFFICIAL
Bill Brooks

21. TITLE OF APPROVING OFFICIAL
Director, Division of Managed Care Operations

22. REMARKS

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approva Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

3. _X_ The following formula is used to determine the needs allowance:
   1. For recipients who live in their own home, the personal needs allowance is 300% of the federal benefit rate (FBR)
   2. For recipients who live in state-contracted residential facility (e.g. adult family home, assisted living facility), the personal needs allowance is 100% of the federal benefit rate (FBR).

   In addition to the personal needs allowance in (1) or (2) , an allowance will be made for (when applicable):
   a) Any court ordered payee and/or guardianship fees;
   b) Any court-ordered guardianship-related costs; plus or related administrative costs; plus
   c) An amount for employed individuals equal to the first $65 of the recipient's earned income, plus one-half of any remaining earned income.

   In any case, the total deductions under (1) or (2), plus additional deductions of (a), (b), and (c), will not exceed 300% of the federal benefit rate.

Note: If the amount protected for a PACE enrollee in item 1 is equal to, or greater than, the PACE enrollee's income, enter N/A in items 2 and 3.

2. Allowance for the maintenance needs of the spouse:
   The amount deducted for the PACE enrollee's spouse is equal to:
   1.____ The SSI federal benefit rate
   2.____ Optional State Supplement Standard
   3.____ Medically Needy Income Level Standard
   4.____ The following dollar amount (provided it does not exceed the amount(s) described in 1-3): $_____
   5.____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
   6._X___ Not applicable (N/A)

3. Allowance of the maintenance needs of the family (check one):
   1.____ AFDC need standard
   2.__X__ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

   3.____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
   4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

3. Allowance of the maintenance needs of the family (check one):
   1.____ AFDC need standard
   2.____ Medically needy income standard

   The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

   3.____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
   4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
   5.____ The amount is determined using the following formula:
   _____
   _____
   6.____ Other
   7.____ Not applicable (N/A)

4. Allowance for medical and remedial care expenses, as described in 42 CFR 435.735 (c)(4).

Spousal Post Eligibility

State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance consistent with the minimum monthly maintenance needs allowance described in section 1924(d), a family allowance, for each family member, calculated as directed by section 1924(d)(1)(C), and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.
Yes _X_ No ____

Note: states must elect the use the post-eligibility treatment-of-income rules in section 1924 of the Act in the circumstances described in the preface to this section.

(a.) Allowances for the needs of the:
   1. Individual (check one)
   (A).____The following standard included under the State plan (check one):
      1. _____SSI
      2. _____Medically Needy
      3. _____The special income level for the institutionalized
      4. _____Percent of the Federal Poverty Level: _____%.
      5._____Other (specify):_____

   (B)._____The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.