Spending plan for Implementation of the American Rescue Plan Act of 2021, Sect. 9817

Additional support for Medicaid home and community-based services during the COVID-19 public health emergency

Updated October 2021
Originally Submitted June 2021

Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

October 18, 2021

Jennifer Bowdoin
Director, Division of Community Systems Transformation
Center for Medicaid and CHIP Services
7500 Security Boulevard
Baltimore, Maryland 21244

SUBJECT: Updated spending plan to implement the American Rescue Plan Act (ARPA) of 2021

Dear Ms. Bowdoin,

On June 11, 2021 the State of Washington submitted its initial section 9817 ARPA spending plan to the Centers for Medicare & Medicaid Services (CMS). Since that time CMS has requested additional information (RAI) from the state twice, on July 23, 2021 and September 3, 2021, and the state has responded to each of these requests, on August 11, 2021, September 24, 2021 and October 7, 2021.

CMS also requested that the state submit an updated version of their ARPA spending plan that includes any additional information provided by the state during the review and RAI process. Our submission also notates the three initiatives that CMS indicated would not be approved in its partial approval letter dated September 3, 2021.

The state of Washington will continue to update CMS on its implementation of section 9817 via quarterly spending plan submissions. Rebecca Carrell, Deputy Director Medicaid Programs, will coordinate our quarterly submissions. Please direct any questions to me and Ms. Carrell at rebecca.carrell@hca.wa.gov. Washington State appreciates this opportunity and your partnership in this effort.

Sincerely,

Charissa Fotinos MD, MSc

Charissa Fotinos, MD, MSc
Acting Medicaid Director

STATE OF WASHINGTON

June 11, 2021

Anne Marie Costello
Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services
7500 Security Boulevard
Baltimore, Maryland 21244

SUBJECT: Spending plan to implement the American Rescue Plan Act of 2021

Dear Ms. Costello,

On May 13, 2021, the Centers for Medicare & Medicaid Services (CMS) provided guidance to the state on implementation of section 9817 of the American Rescue Plan Act (ARPA) of 2021. Specifically, it outlined the eligible services and the program requirements that state Medicaid programs must comply with to receive the enhanced Federal Medical Assistance Percentage (FMAP) provided in section 9817 and directed the state to submit a spending plan that outlines how it will invest in home and community-based services (HCBS) programs.

The state of Washington's initial spending plan outlines targeted investments of which our Legislature has already appropriated that will enhance and expand its HCBS services and programs for the state's most vulnerable residents, while ensuring compliance with the following requirements:

- The federal funds attributable to the increased FMAP will be used to supplement and not supplant existing state funds invested in Medicaid HCBS programs in effect as of April 1, 2021.
- The state is using the funds attributable to the increased FMAP to both supplement current HCBS activities and to implement activities designed to substantially enhance its Medicaid HCBS programs.
- The state has not made changes to HCBS eligibility standards, methodologies or procedures that are stricter than the policies that were in place on April 1, 2021.
- The investments that the state is making to HCBS programs preserve the programs and services, including the amount, duration and scope of the services that were in place as of April 1, 2021.
- The state continues to pay HCBS providers at a rate equal to, or more than, the rates that were in place as of April 1, 2021.

The state of Washington will continue to update CMS on its implementation of section 9817 via quarterly spending plan submissions. Rebecca Carrell, Deputy Director Medicaid Programs, will coordinate our quarterly submissions. Please direct any questions to me and Ms. Carrell at rebecca.carrell@hca.wa.gov. Washington State appreciates this opportunity and your partnership in this effort.

Sincerely,

MaryAnne Lindeblad, BSN, MPH
Medicaid Director

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American Rescue Plan Act of 2021

President Biden signed the American Rescue Plan Act of 2021 (ARPA) on March 11, 2021. Section 9817 of the ARPA provides states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). These services are person-centered care delivered in the home or community to support people who need assistance with everyday activities.

States are required to use the federal funds attributed to the increase FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021. States must use funds equivalent to the amount of federal funds attributed to the increased FMAP to enhance, expand, or strengthen HCBS under the Medicaid program.

Increased FMAP estimates: Washington will receive an estimated $524 million in additional federal funding because of the FMAP enhancement between April 1, 2021, and March 31, 2022. This includes the additional federal funds for current spending as well as the additional federal funds resulting from initial reinvestments.

The table below illustrates state dollars spent on eligible HCBS and rehabilitative behavioral health services that are offset by the FMAP enhancement. The first row represents offsets on base spending. The second row identifies the portion of freed up state funds that are being reinvested to expand, enhance, and strengthen HCBS. The third row illustrates the additional FMAP generate from Washington's initial HCBS investments.

$ in Thousands	FFY 2021	FFY 2022	FFY 2023	FFY 2024	Total
State funds offset by enhanced FMAP - Base spend	207,800	208,215			416,015
State funds reinvested in eligible services	125,122	147,923	TBD	TBD	273,045
Additional FMAP on reinvested funds	56,390	51,793			108,183
Total State funds offset by FMAP Increase	264,190	260,008			524,198

Washington State Legislature allocations and the spending plan: The Washington State Legislature was in session when ARPA was signed into law. As part of the state's 2021-2023 operating budget, the Legislature identified a list of investments to enhance, strengthen, or expand HCBS. That list is the basis for Washington's initial HCBS spending plan. The Legislature invested $273 million in new state spending. These investments are described in detail in the next section and a summary is available as Appendix A.

Washington plans to set aside the remaining $251 million needed to hit our spending targets for future spending subject to legislative deliberations. Many of the investment items were funded in the operating budget on an ongoing basis. However, due to the timing of ARPA passage and CMS spending guidance, Washington's initial investment list only captures spending between April 1, 2021, and March 31, 2022. The Legislature may choose to count spending on ongoing items through March 31, 2024, now that CMS has clarified the spending timeline. The state intends to update the spending plan through the quarterly update process as information emerges. The Medicaid Program also intends to review other services that are not currently delivered through the Rehabilitation portion of the State Plan Amendment (SPA) but could be based on what CMS has previously approved for other states.

> ***On August 13, 2021, the state submitted the following:*** *As described in Washington's original submission, the Legislature identified an initial list of HCBS investments. Many of the items on that initial list were funded on an ongoing basis. However, due the timing of legislative session and CMS guidance on spending guidelines, the Legislature only included months of that spending as part of the initial list. If the Legislature chooses to count spending between April 1, 2021, through March 31, 2024 for those same items identified in Washington's initial spending list, the amounts would be as follows:*

$s in Thousands		FFY 2021	FFY 2022	FFY 2023	FFY 2024	Total
State funds offset by enhanced FMAP - Base spend		207,800	208,215	-	-	416,015
State funds reinvested in eligible services		114,784	244,615	218,173	113,891	691,464
Additional FMAP on reinvested funds		50,874	40,762	-	-	91,636
Total State funds offset by FMAP Increase		258,675	248,976	-	-	507,651

Under this scenario, the State will have exceeded its non-supplant target as illustrated in the table above. The Legislature would then need to choose which specific items to count toward the non-supplant target. It is also possible that the Legislature will identify a different set of spending items for FFY 2023 and FFY 2024. Washington intends to update the spending plan through the quarterly update process as more information is available. Please note, while revising our initial estimates to create the table above, Washington noticed a few FMAPs that needed to be adjusted slightly. This is what accounts for the difference in line three between the table above and Washington's original submission.

Washington can confirm that it is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services that were in placed as of April 1, 2021.

For any activities focused on behavioral health providers or people with mental or substance use disorders, clearly indicate if any of the activities are: focused on behavioral health providers that are not delivering services that are listed in Appendix B or could be listed in Appendix B; or targeting individuals with mental or substance use disorders who are not receiving any of the services listed in Appendix B or services that could be listed in Appendix B. If any activities

Home and Community-Based Services spending plan

The HCBS investment opportunity will allow Washington to make substantial investments in the HCBS programs that directly impact the lives of our most vulnerable populations, including individuals with disabilities, experiencing homelessness, people with behavioral health needs and other adults.

Washington's spending plan outlines targeted investments that:

- Improve access to services.
- Support client transitions from institutional to community-based settings.
- Expand HCBS service offerings.
- Provide additional support to providers.
- Address critical workforce development and expansion needs.

The initiatives below make investments in areas that are critical to Washington's HCBS system to address both the short- and long-term needs of Washington residents.

Increased funding to support transitions from institutional to community-based settings

The transition initiatives below serve to enhance and expand existing community-based programs. Strengthening the transition services reduce health disparities among older adults, clients with behavioral health needs, and those recovering from substance use disorders. These initiatives support whole person care and create pro-social determinants of health (SDOH) by supporting positive transitions, including services in places where people live, learn, work, and play.

Transitions and diversions from psychiatric state hospitals: Beginning in January 2022, funding and full-time employees have been allocated to support the transition of civil patients in state and local psychiatric hospitals to community settings. Funding is sufficient to support an additional 120 individuals who have a need for community-based services in licensed residential settings that have additional staffing and training to address their needs of long-term services and supports.

Transitions from acute care hospitals to geriatric and dementia specialty providers in the community: Funding is provided for incentive payments to contracted Department of Social and Health Services (DSHS) providers who accept clients being discharged from acute care hospitals. This is part of an effort to create and maintain COVID-19 surge capacity in acute care hospitals. Funding is sufficient to phase in an additional 185 individuals who have a need for community-based services in licensed residential settings that have additional staffing and training to address their needs for long-term services and supports.

Hospital surge, non-citizens: Funding is provided for community supports to contracted DSHS providers who accept clients being discharged from acute care hospitals. This is part of an effort to create and maintain COVID-19 surge capacity in acute care hospitals. Funding is sufficient to phase in placements for 20 individuals who are ineligible for Medicaid due to citizenship status at an average daily rate of $225 per-client per-day. This is critical for the Medicaid system because it streamlines the pathway to both Medicaid HCBS and allows acute care hospitals to provide care to patients who are truly in need of hospital care, especially when still dealing with COVID-19 related surges.

> ***On August 13, 2021, the state submitted the following:*** *The Hospital surge project expands and enhances HCBS under Medicaid by allowing non-citizens who are stuck in hospitals and do not meet medical necessity requirements to be served in the community. The funding will provide much needed HCBS services to individuals who are in the process of becoming citizens. These activities not only better serve individuals living in Washington by affording them the opportunity to live in a setting of their choice with paid home and community-based supports, but they also ensure needed capacity in acute care hospitals, which has been exacerbated by the COVD-19 pandemic.*

Transitions from skilled nursing facilities to in-home (rental subsidies): A state-funded housing program is created to help clients transition from nursing homes to their own homes in the community. Since the cost of a nursing home placement exceeds the cost of an average client's in-home personal care services, General Fund-State (GF-State) savings are achieved after the cost of the rental subsidies and staff support are accounted for. DSHS plans to phase in 300 subsidized housing opportunities at an average subsidy of $775 per month to support individuals who otherwise would not be able to transition from a skilled nursing facility. This is critical to serve Medicaid clients and prevent homelessness and the resulting critical and emergency treatment that often results, especially with behavioral health conditions.

Conditionally released sexually violent predators: Funding and staffing is provided to implement Engrossed Second Substitute Senate Bill 5163 DSHS will perform discharge planning for aging and disabled civilly committed residents to develop the initial and ongoing care plans for these individuals. This provides critical Medicaid HCBS system opportunities in the community that would otherwise have significant problems upon transition.

> ***On August 13, 2021. the state submitted the following:*** *The anticipated outcome of this activity is to increase the number of providers willing to serve this population and to create access to services for this population while also balancing the need to protect vulnerable adults. A small percent of the conditionally released sexually violent individuals are in need of HCBS services. Currently, it very difficult to find HCBS providers who are willing and able to serve this population while also meeting requirements to meet the health and safety needs of other they may be also serving. We anticipate this funding will serve an additional 20 Medicaid-eligible individuals to be served in HCBS settings once they transition.*

PASRR capacity increase: Funding is provided for expansion in the caseload and per-capita cost of clients with intellectual and developmental disabilities receiving Preadmission Screening and Resident Review (PASRR) services. The services provided are services also approved through 1915(c) waivers. The success of Washington's PASRR program has been through services that target HCBS including community engagement, employment supports and other services that support discharge back to the community.

Peer mentor program: Ongoing funding is provided to support four peer mentors, one for each Residential Habilitation Center, to help transition residents from state facilities to homes in the community. A combination of the federal Roads to Community Living grant and General Fund-State dollars are used to fund the mentors. Establishment of a peer mentor

program will enhance HCBS by creating an avenue for those considering or planning to move to an HCBS setting to connect to a peer with similar or related experience.

Increase services offered based upon assessed need

The investments in this section target increases designed to expand existing, and provide additional in-home personal care hours, reduce the number of clients waiting for services, reduce the amount of time an individual is waiting for services, and enhance other highly effective programs.

Shared benefit adjustments: DSHS is making rules to change the way that in-home clients' assessed care hours are determined. Funding is provided for an anticipated increase in in-home personal care hours. This expands HCBS in Washington by increasing benefit amounts to individuals who previously had client hours adjusted for shared benefits.

HCBS supports: One-time funding is provided for durable medical equipment and minor home renovations needed to improve mobility and accessibility of long-term services and supports clients. These funds are intended to serve both existing clients and those waiting for services. The HCBS system is strengthened through targeted funding to support environmental adaptations and equipment purchasing, which will improve the stability of those in the community and those waiting for services.

Parent Child Assistance Program (PCAP) expansion: Funding is provided to expand services to pregnant and parenting women in the PCAP, which is a critical Medicaid service in the state. PCAP is an award winning, evidence-informed home visitation case-management model for pregnant and parenting women with substance use disorders. PCAP goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs.
Pregnant and parenting women are enrolled in PCAP for three years. PCAP forms partnerships with and between clients and families and community service providers. PCAP provides participants outreach, engagement, structured goal setting, practical assistance, and coaching to help community service providers understand how to work more effectively with participants and to ensure participants receive needed services.

Expand SUD services and supports: One-time funding is provided to expand substance use disorder services and supports including amounts for prevention, outreach, treatment, recovery supports, and grants to tribes.

> ***On August 13, 2021. the state submitted the following:*** *Providers that are to receive payments are delivering services listed in Appendix B. Additionally, the providers will provide services that are not currently listed in Appendix B. Those services not currently listed in Appendix B include HCA's efforts to increase outreach to individuals who may be currently eligible for Appendix B services to assist in increased rates of identification, initiation, and engagement in treatment, and allowing for increased adherence to retention in treatment. This can strengthen HCBS under Medicaid as these services will produce a reduction in overdose deaths, particularly those due to opioids, a reduction in utilization of emergency departments and inpatient hospital settings for treatment where the use is preventable, and reduction in readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. Additionally, these outreach services are intended to improve access to care for potential beneficiaries' behavioral health and physical health conditions while improving community/individual knowledge of available services.*
>
> ***On September 24, 2021. the state discussed the following with CMS:*** *The state confirms that providers receiving payments are delivering services listed in Appendix B.*

Expand and enhance services available in the community to improve access to HCBS and delay/divert individuals from institutional services

These initiatives target investments that expand and improve access to community-based services. A strong community-based network of providers reduces access to care barriers, increases a client's ability to receive services in a timely manner, and promotes recovery. As with many of our initiatives, these create pro-SDOH by providing services in the community to ensure that services are delivered in the less restrictive setting, and is inclusive of places where people live, learn, work, and play.

Dementia Action Collaborative: Funding is provided for efforts to support individuals with dementia and their families, including two Dementia Resource Catalyst staff positions at the Area Agencies on Aging (AAAs), with one staff position east of the Cascades and one west of the Cascades, and for direct supportive services. This expands and enhances HCBS by reaching more individuals and families in need of long-term services and supports in relation to a dementia diagnosis.

Fall prevention training: One-time funding is provided for DSHS to contract with an association representing long-term care facilities to develop and provide fall prevention training for long-term care facilities. This strongly supports the Medicaid HCBS program and patients as a preventive measure.

> ***On August 13, 2021, the state submitted the following:*** *The budget bill (SB 5092, Section 204(36)) passed by the Washington state legislature this year stipulates that the training shall be developed and provided by an association representing long term care facilities, which could include associations representing nursing homes as well as HCBS providers. Only approximately 11 percent of Washington's 70,000 Medicaid long-term services and supports clients are served in nursing homes, the rest are served in HCBS settings. The legislature stipulated that the training is to be made available on-line and be accessible to the general public as well as to caregivers in long term care settings. The large majority of providers and clients receiving the training will be from in-home or community residential settings.*

Intellectual/Development disability summer programs: Funding is provided for summer programs for those with intellectual and development disabilities. Funding for summer programs strengthens HCBS by supporting school age youth receiving Medicaid residential services up to age 21 with activities when the school services are not available.

Washington confirms that the following item has been removed from the spending plan per CMS' September 3, 2021 letter:

> ~~**Personal Needs Allowance (DSHS):** Funding is provided for a cost-of-living-adjustment (COLA) on the Personal Needs Allowance (PNA) for DSHS Medicaid clients living in nursing homes and residential settings in the community. The PNA represents the amount of a Medicaid client's income that they may keep for personal expenses rather than contributing to the cost of their care. Funding is sufficient to increase the PNA by an estimated 1.5 percent on January 1, 2022, and an additional 1.5 percent on January 1, 2023. PNA adjustments in line with COLA helps individuals maintain stability in an HCBS setting.~~

Subminimum wage: Funding is provided for the Department to work with employment providers to assist individuals with intellectual and development disabilities who are employed in subminimum wage jobs to transition into minimum wage or better employment. This funding will strengthen HCBS by transitioning those still in subminimum wage positions to competitive employment offering at least the minimum wage or better.

Community residential options: Funding is provided to phase-in five, three-bed community-based, State-Operated Living Alternatives (SOLA) homes; 12 beds in supported living settings; and four beds in Adult Family Homes in order to expand community placement options for individuals with intellectual and developmental disabilities by the end of June 2023. Expansion of the number of beds offered in state-operated setting will improve access to services for adults who need habilitative residential supports. This funding is also tied to expansion in a DDA Medicaid waiver offering residential habilitation.

> ***On September 24, 2021, the state submitted the following:*** *Capital investments are not included in the funding for community residential options or children's SOLA. These appropriations provide funding for staff to deliver the services of Residential Habilitation which supports individuals to live in their own homes in the community. Residential Habilitation is a service on the Core and Community Protection 1916(c) waivers.*

Children's SOLA: Funding and staffing are provided for four new community-based State-Operated Living Alternative (SOLA) homes to serve a total of 12 children and youth with developmental disabilities age 20 and younger. Client placements will be phased in by June 2023. Expansion of the number of home placement offered in state-operated setting will improve access to services for children who may not otherwise receive the habilitative services needed to live in a community setting. This funding is also tied to expansion in a DSHS waiver offering residential habilitation.

> ***On September 24, 2021, the state submitted the following:*** *Capital investments are not included in the funding for community residential options or children's SOLA. These appropriations provide funding for staff to deliver the services*

of Residential Habilitation which supports individuals to live in their own homes in the community. Residential Habilitation is a service on the Core and Community Protection 1916(c) waivers.

Dan Thompson community investments: This is a critical general community services investment for those with intellectual and developmental disabilities to help with HCBS needs. Under RCW 71A.20.170 funding in this account may only be used for supports and services in a community setting to benefit eligible persons with developmental disabilities.

High school transition students: Funding is provided for DSHS for an estimated 102 youth with developmental disabilities transitioning out of public schools to receive employment and day services. Once enrolled in a waiver, clients are entitled to all services under that waiver that DSHS has assessed and authorized. Capacity expansion of the Basic Plus waiver will support individuals exiting high school transition programs to have long-term employment supports.

Increase CIIBS waiver capacity: Funding and staff are provided to increase the capacity of the Children's Intensive In-home Behavioral Supports (CIIBS) waiver by 100 children, which represents a doubling of the current caseload. The CIIBS waiver serves DDA-eligible children who live in their own homes and have behavioral health challenges. Expansion of the CIIBS waiver will double the size of this waiver, strengthening the state's support to children and families and reducing risk of out-of-home placement.

On September 24, 2021, the state discussed the following with CMS: *Individuals enrolled on a 1915c waiver through capacity expansion will have access to the services approved by CMS in the Children's Intensive In-Home Behavior Supports, Individual and Family Services and Basic Plus 1915(c) waivers.*

Increase IFS and Basic Plus waivers: Funding is provided for expanded capacity of 923 slots for the Individual and Family Services waiver and 467 slots for the Basic Plus waiver. This funding expands capacity in two HCBS waivers.

On September 24, 2021, the state discussed the following with CMS: *Individuals enrolled on a 1915c waiver through capacity expansion will have access to the services approved by CMS in the Children's Intensive In-Home Behavior Supports, Individual and Family Services and Basic Plus 1915(c) waivers.*

Increase Core and CP waivers: Funding is provided for expanded capacity of three Community Protection waiver slots and to continue a phase-in of 159 slots for the Core waiver. This funding expands capacity in two HCBS waivers.

On September 24, 2021, the state discussed the following with CMS: *Individuals enrolled on a 1915c waiver through capacity expansion will have access to the services approved by CMS in the Children's Intensive In-Home Behavior Supports, Individual and Family Services and Basic Plus 1915(c) waivers.*

Trueblood Phase 2 implementation: The Trueblood v. DSHS (Trueblood) lawsuit challenged unconstitutional delays in competency evaluation and restoration services for people detained in jails. This is an important measure that supports access treatment options in an individual's community as opposed to a state institution. The first phase, funded in the 2019-21 budget, included Pierce and Spokane counties and the southwest region of Washington. The second phase will include King County. The agreement outlines projects to implement outpatient competency restoration programs, residential supports and case management services.

- Add inpatient restoration services capacity.
- Ramp down alternate restoration facilities in Yakima and Maple Lane.
- Create forensic navigator positions to facilitate the information sharing needed between the courts, class members, providers, and DSHS.

Many of the problems with untimely competency evaluations are preventable, and attributable to potential unmet needs in the community. If fewer people with mental illness enter the criminal justice system and receive supports in HCBS settings, which these services support, we are helping to divert institutionalization. When people are able to get the treatment they need when they need it, they are more likely to avoid the criminal justice system, be more productive and healthier; thus avoiding more costly Medicaid system care.

On August 13, 2021, the state submitted the following: *According to the Research and Data Analysis (RDA) Cross-System Outcome Measures for Adults Enrolled in Medicaid dashboard, there are 708,117 individuals enrolled in Managed Care (2020Q2). Of those individuals, 43,988 individuals were arrested that same quarter. According to the same report, it is estimated that 266,659 individuals enrolled in MCOs have a treatment need or 38 percent.*

The Trueblood Settlement Agreement consists of a number of projects that are intended to reduce unconstitutional delays in competency evaluations or restorations as well as programs to divert individuals from intersecting with the legal system. Washington has struggled to meet the timeliness standards to avoid unconstitutional delays in competency evaluations. One of the fourteen projects in the settlement agreement consist of providing competency restoration services in community settings instead of inpatient settings for individuals charged with misdemeanor or non-violent felonies. These services aimed at educating individuals about the legal process and provide support to increase the person's ability to participate in their own defense and is coupled with outpatient behavioral health treatment. Utilizing the nationally recognized Breaking Barriers curriculum, a multi-disciplinary team conducts classes aimed at increasing the individuals understanding of the legal process.

Approximately half of the Trueblood class members experienced homelessness at the time of their charges or in the 12 months prior to their court-ordered competency evaluation. Assisting individuals to be successful in transitioning from incarceration, or their success in outpatient competency restoration, is dependent on access to are and affordable housing. Using a successful model to help individuals transition from inpatient settings, Trueblood includes a project called Forensic Housing and Recovery through Peer services (F-HARPS). Using certified peer counselors to help individuals obtain and maintain housing combines tenancy support services combined with transitional housing subsidies allows individuals to rapidly access shelter and housing as soon as they leave jail.

Forensic Navigators assist the individual to 'navigate' the legal system while assisting the individual to obtain community-based services and resources. Ordered by the court, Forensic Navigators maintain extremely close contact with jail and court partners in order to serve individuals clients. Similarly, forensic navigators have maintained this same close contact with all forensic services partners in Outpatient Competency Restoration Program (OCRP), Forensic Project for the Assistance in Transitions from Homelessness (FHARPS), and Forensic Projects for Assistance in Transition from Homelessness (FPATH); as well as community-based service providers whom they work with on behalf of shared participants.

FPATH is modeled after traditional PATH (Projects for Assistance in Transition from Homelessness) programs. The Trueblood Settlement Agreement refers to this program as "intensive case management." Teams within community behavioral health agencies are multidisciplinary that include certified peer counselors who have lived experience in behavioral health recovery, as well as outreach workers, housing specialists and mental health professionals. These teams are building relationships with people in the community and help connect them with supports to include housing, transportation and health care services. FPATH connects identified individuals who are at risk of referral in the next six months for competency restoration (which the settlement agreement calls "high utilizers") with services.

The Substance Abuse Mental Health Services Administration (SAMHSA) created the National Guidelines for Crisis Care – A Best Practice Toolkit advances national guidelines in crisis care toolkit that supports program design, development, implementation and continuous quality improvement efforts. Within the toolkit, SAMHSA identified increasing mobile crisis response (MCR) and crisis stabilization services as strategies to reduce the intersection between behavioral health and law enforcement. In the Phase 2 Trueblood Settlement, HCA has invested significant resources to enhance and expand both MCR and crisis stabilization services.

Washington confirms that the following item has been removed from the spending plan per CMS' September 3, 2-2021 letter:

~~**Children's Long-Term Inpatient Program (CLIP) habilitative mental health facility:** Ongoing funding is provided for the state to contract for a community-based 12-bed CLIP specializing in the provision of habilitative mental health~~

~~services for children and youth with intellectual or developmental disabilities who have intensive behavioral health support needs. This is a critical HCBS investment to support community-based care and prevent institutional care. Start-up funding is provided in FY 2022 and ongoing operational funding is provided beginning in July 2022.~~

~~***On August 13, 2021 the state submitted the following:*** The CLIP HMH is an institutional setting not an HCBS.~~

Per CMS' September 3, 2-2021 letter, this initiative below is not approved, Washington respectfully requests that CMS reconsider this determination:

CMS' policy paper, SHO #21-001, to State Medicaid Directors it does indicate:

"A. Housing-Related Services and Supports Federal financial participation is not available to state Medicaid programs for room and board (except in certain medical institutions13).14 However, federal financial participation is generally available under certain federal authorities for housing-related supports and services that promote health and community integration, including home accessibility modifications, one-time community transition costs, and housing and tenancy supports, including pre-tenancy services and tenancy sustaining services." Washington believes that the housing short-term subsidies referenced in the initiative below are consistent with one-time community transition costs.

Short-term behavioral health housing support: Ongoing funding is provided for this HCBS program for short-term and long-term rental subsidies and recovery housing for individuals with mental health or substance use disorders. Numerous studies have demonstrated that addressing the social determinants of health through housing, employment, transportation, and nutrition can improve an individual's overall health. To connect individuals to stable housing, rental subsidies are needed to access housing either through the public affordable housing system or through private market landlords. Subsidies coupled with supportive housing services are being implemented through multiple venues such as Foundational Community Supports (1115 Medicaid waiver), Housing and Recovery through Peer Services (HARPS), Forensic HARPS, and through regional behavioral health administrative service organizations (BHASOs). Short-term subsidies are used to bridge individuals exiting inpatient behavioral health settings until long-term housing subsidies can be obtained. Long-term subsidies are administered by the Department of Commerce through the Community Behavioral Rental Assistance Program (CBRA).

On August 13, 2021 the state submitted the following: *The amounts identified in the spending plan are 65% of the total provided in the budget. Washington assumes that 65% of the clients that receive these services would be Medicaid eligible.*

According to the Research and Data Analysis (RDA) Cross-System Outcome Measures for Adults Enrolled in Medicaid dashboard, there are 174,491 individuals with a substance use treatment need on Medicaid. Of that total, 50,103 meet the broad definition of homelessness (includes 'couch surfing'). These tabulations are limited to persons aged 18-64 meeting continuous enrollment criteria used for performance measure reporting. The total count of persons with substance use treatment needs who experience homelessness or housing instability and are enrolled in Medicaid for at least part of the year is much higher. State Fiscal Year (SFY) 2012 data show that 14,285 Medicaid beneficiaries with "any housing needs" who were in the top cost decile had annual health care costs of $29,584 per person on average. Of this group, 1,412 people had average annual health care costs of $107,959 per person according to the Creating a Medicaid Supportive Housing Services Benefit report (WLIHA, 2014). In addition, a report issued in 2012 from RDA entitled The Housing Status of Individuals Leaving Institutions and Out-of-Home Care: A Summary of Findings from Washington State found:

1. The rate of homelessness among individuals leaving institutional and out-of-homecare settings is quite high. More than one-quarter of all five study populations experienced homelessness at some point over a 12-month follow-up period. By contrast, only 9 percent of the DSHS client population as a whole was homeless in SFY 2010 (n = 184,865 of 1,946,302).

2. Individuals leaving residential chemical dependency treatment facilities and prisons represent particularly high opportunity populations. They were more likely—in both proportion and volume—to experience homelessness but as likely as other groups to exit to permanent housing when they received housing assistance recorded in HMIS.

3. Across the five groups, the proportion of individuals in need of housing who received it was highest for youth aging out of foster care (at 35 percent). Given that the Independent Youth Housing Program is dedicated to providing housing to youth in their transition out of foster care, this finding suggests that targeting housing resources to specific at-risk populations can have an impact on housing assistance penetration rates. This has also been demonstrated with the state's Housing and Essential Needs (HEN) program.

Housing subsidies are issued through HARPS and FCS programs. Both the Housing and Recovery through Peer Services (HARPS) and the Foundational Community Supports (FCS) programs use the permanent supportive housing (PSH) model to provide services to assist individuals obtain and maintain housing. Principles of the PSH model are based on individual's choice in housing as well as low barrier and harm reduction approaches. Transitional housing subsidies pay for deposits, application fees, first/last month's rent until long-term subsidies can be acquired.
Supportive housing services consist of pre-tenancy and pos-tenancy support services such as contacting landlords on a person's behalf, teaching a person to budget or complete household tasks. Initial evaluation results of the FCS services program indicate reductions in emergency room and inpatient hospitalizations and connection to housing programs operated by the Department of Commerce (Danielson et all, 2020).

Adult and youth mobile crisis teams: Funding is provided for increasing local behavioral health mobile crisis response team capacity and ensuring each region has at least one adult and one children and youth mobile crisis team that is able to respond to calls coming into the 988-crisis hotline. The state will ensure creation of a minimum of six new children and youth mobile crisis teams, and that there is one children and youth mobile crisis team in each region by the end of fiscal year 2022. The state will establish standards in contracts with managed care organizations and BHASOs for the services provided by these teams.

Mobile integrated health pilot: Funding is provided for a pilot project to provide mobile integrated health services for residents who cannot navigate behavioral health and primary care resources through typical methods through brief therapeutic intervention, biopsychosocial assessment, and referral, and community care coordination.

Outreach or intensive case management: The state will contract with BHASOs to implement statewide recovery navigator programs, which provide HCBS community-based outreach and case management services based on the Law Enforcement Assisted Diversion (LEAD) model. Recovery navigators will accept referrals from the criminal legal system, community outreach organizations, emergency departments and emergency medical services. The program will provide community case management services to non-Medicaid and Medicaid eligible individuals. It is critical that this serves all people as law enforcement cannot check Medicaid eligibility, but this in turn greatly supports and builds a successful HCBS Medicaid system. The response will be field-based and prior to clinical diagnosis. The goal is to meet individuals where they are, while addressing their needs through a housing first/harm reduction model, prior to engagement with any formalized treatment program. Once the acute needs of the individual have been addressed, navigators will refer to medical, social, educational, and other services. Funding has been provided through June 30, 2023.

Short-term substance use disorder housing vouchers: Senate Bill 5476 amends provisions relating to criminal justice and substance use disorder treatment in response to the State v. Blake decision. The bill includes an appropriation for short-term housing vouchers for individuals with substance use disorders. Short-term subsidies are used to bridge individuals exiting inpatient behavioral health settings until long-term housing subsidies can be obtained. Long-term subsidies are administered by the Department of Commerce through the Community Behavioral Rental Assistance Program (CBRA). This is critical HCBS work that substantially supports the Medicaid program because housing is critical to prevent worsening health conditions.

Recovery residences: Senate Bill 5476 adds provisions relating to criminal justice and substance use disorder treatment in response to the State v. Blake decision. The bill includes an appropriation to increase recovery housing availability through partnership with private landlords, increase accreditation of recovery residences statewide, operate a grievance process for resolving challenges with recovery residences, and conduct a recovery capital outcomes assessment for individuals living in recovery residences. Washington is required to: Create and maintain a registry of approved recovery residences in Washington; Contract with the state affiliate of the National Association for Recovery Residences to provide technical assistance to residence operators; and Establish and manage an operating and a capital revolving loan fund to provide funds to recovery residence operators. This is critical HCBS work that substantially supports the Medicaid program because housing is critical to prevent worsening health conditions.

On September 24, 2021, the state submitted the following: *Capital investments are not included in the funding for the recovery residences activity. These appropriations provide funding for ensuring the quality of recovery residences are in-line with the National Alliance of Recovery Residences (NARR) standards and to facilitate stronger relationships between private market landlords. Recovery Residences provide individuals with mutually supported recovery through shared housing post inpatient substance use treatment. This is critical HCBS work that substantially supports individuals enrolled in the Medicaid program because housing is critical to prevent worsening health conditions and supports individuals in their recovery path.*

On October 7, 2021, the state submitted the following: *Activities under this project will include staffing supports, training and technical assistance to environments where individuals share housing in mutually supported recovery. Recovery Residences and Recovery Houses provide an environment where individuals participate in a program of care and treatment with social, vocational, and recreational activities designed to aid individuals diagnosed with substance use disorder in the adjustment to abstinence and to aid in job training, reentry to employment, or other types of community activities, excluding room and board. The majority of individuals in recovery residences and recovery homes are on Medicaid but we do not have the specific data that shows who may be living in these settings. We can assume, based on the percentage of individuals who participate in substance use treatment services, that a great percentage of them will be Medicaid eligible and enrolled. We do know that over 26 percent of Medicaid enrolled individuals with a substance use diagnosis were homeless in the fourth quarter of 2020. This definition of homelessness includes couch surfing and unstably housed.*

In a 2012 evaluation conducted by WA's Research and Data Analysis, in the 12 months following a client's last discharge month that nearly half of the 9,909 clients discharged from residential chemical dependency (CD) treatment facilities had an indication of housing need, yet only 18 percent of those in need received housing assistance recorded in Homeless Management Information System. Of particular note, 32 percent of residential CD treatment facility leavers and 39 percent of state mental hospital leavers had housing need identified through the chemical dependency and mental health systems, respectively. Washington is attempting to create a menu of options to meet these social determinants of health needs by providing an array of options to individuals in order to create choice and community-based options. Recovery Residences and Recovery Houses contribute to those community-based options.

Clubhouse expansion: Clubhouse programs benefit individuals in mental health recovery. Based on the core principles of peer support, self-empowerment, and functionality within a community setting, Clubhouses strive to help members:

- Participate in mainstream employment and educational opportunities.
- Find community-based housing.
- Join health and wellness activities.
- Reduce hospitalizations.
- Reduce involvement with the criminal justice system.
- Improve social relationships, satisfaction and quality of life.

A workgroup consisting of external stakeholders, subject matter experts and people with lived experience made a recommendation to expand the definition of Clubhouse programs to include more consumer-run, consumer-operated and recovery café-type services. The Legislature has provided funding over time for existing Clubhouse services, developing new programs, and developing options for Washington Apple Health (Medicaid) funding. Senate Bill 5476 amends provisions relating to criminal justice and substance use disorder treatment in response to the State v. Blake decision. The bill includes appropriations for implementation of Clubhouse services in every region of the state.

Homeless outreach stabilization: Outreach and engagement are fundamental to diverting people from incarceration and crisis services. SAMHSA has funded homeless outreach and engagement through the Projects for Assistance in Transition from Homelessness (PATH) for many years. Limitations to PATH are the focus on people with just a suspected serious mental illness

and limited resources ($1.3M is allocated to Washington), including a match requirement (33 percent match to federal funds). Washington expanded outreach and engagement efforts to the SUD population through the State Opioid Response grant creating the Peer Pathfinder program. The goals of PATH and Peer Pathfinder are to engage and conduct outreach efforts to connect individuals to treatment and resources. Senate Bill 5476 (State v. Blake decision) creates an opportunity to conduct outreach and engagement but bring treatment to an individual rather than connecting or linking them to treatment. The bill includes an appropriation to implement homeless outreach stabilization teams (HOST) consisting of mental health, substance use disorder, and medical professionals. This multi-disciplinary team provides treatment to individuals who are experiencing homelessness. The teams help individuals with behavioral health disorders access necessities, nursing and prescribing services, case management, and stabilization services. A HOST program will be established in each of the 10 regional service areas.

> ***On August 13, 2021, the state submitted the following:*** *The amounts identified in the spending plan are 65% of the total provided in the budget. Washington assumes that 65% of the clients that receive these services would be Medicaid eligible. Each year the U.S. Department of Housing and Urban Development (HUD) and Washington state require a statewide count of all persons staying in temporary housing programs (sheltered count) and places not meant for human habitation (unsheltered count). In January 2020 there were 22,923 individuals identified as homeless on that specific point in time count in Washington State. Of that number, 10,814 were unsheltered (living in places not meant for human habitation). 6,609 individuals self-identified as having a serious mental illness (4,743 of those same individuals were unsheltered) and 5,298 individuals self-identified as having a substance use disorder (3,876 of those same individuals were unsheltered).*
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> *According to the Research and Data Analysis (RDA) Cross-System Outcome Measures for Adults Enrolled in Medicaid dashboard, there are 174,491 individuals with a substance use treatment need on Medicaid. Of that total, 50,103 meet the broad definition of homelessness (includes 'couch surfing'). That same dashboard report indicates there are 446,570 Medicaid enrolled individuals with a mental health treatment need with 62,469 individuals that meet the broad definition of homeless. These tabulations are limited to persons aged 18-64 meeting continuous enrollment criteria used for performance measure reporting. The total count of persons with substance use or mental health treatment need who experience homelessness or housing instability and are enrolled in Medicaid for at least part of the year is much higher.*
>
> *Expanding services to meet the needs of individuals with behavioral health treatment needs 'where they are at' means that we need to bring the services to the individual rather than require the individual to access services within a facility. Washington's efforts to conduct outreach and engagement services to some of our most vulnerable require a multi-disciplinary team approach using assertive and persistent outreach and engagement. PATH, Peer Pathfinder and HOST teams enhance the treatment system by engaging individuals who may be frequent utilizers of emergency rooms, inpatient and institutional settings.*

Safe station pilot programs: Per Senate Bill 5092, grants will be awarded to fire departments to implement safe station pilot programs. Programs may combine the safe station approach with fire department mobile integrated health programs such as the community assistance referral and education services program under RCW 35.21.930. Certified substance use disorder peer specialists may be employed in a safe station pilot program. The pilot programs will collaborate with BHASOs, local crisis providers, and other stakeholders to develop a streamlined process for referring safe station clients to the appropriate level of care. This supports the Medicaid system as an integral part of our HCBS behavioral health response.

Opioid treatment network: Senate Bill 5476 amends provisions relating to criminal justice and substance use disorder treatment in response to the State v. Blake decision. The bill includes an appropriation to expand opioid treatment network (OTN) programs for people with co-occurring opioid and stimulant use disorder to provide direct treatment options. The state contracts with 15 organizations: Seven emergency departments, five jails, one syringe exchange, one shelter, and one fire department, creating the existing opioid treatment networks (OTNs). These networks, also known as initiation sites, provide: medication for individuals experiencing opioid use disorder; funding to build OTN infrastructure; funding for staff; and facilitation to transition individuals to community treatment providers. Expansion of OTNs could include shelters, fire departments, syringe exchanges, and community day centers to ensure sites are meeting individuals where they are in the community and providing the first pathway to treatment. Estimated cost for a new OTN site is $450,000 per year. Also needed is an additional $33,000 per site, per year for training and technical assistance and $25,000 per site, per year for program evaluation and data collection, for a total of $508,000 for each new site, per year. Depending on the number of expansions, an

optional expense for 1 FTE to provide technical assistance, fiscal, and contractual oversight is budgeted at $125,000 annually. Medicaid currently supports this funding, and this ARPA funding will help grow this critical Medicaid HCBS opportunity to help people needing services.

Housing Trust Fund: Funding is provided to develop and provide housing for individuals with intellectual and developmental disabilities through the Housing Trust Fund program. The source of the funds is General Fund-State savings due to the enhanced Federal Medicaid Assistance Percentages provided through ARPA.

Washington has limited housing availability and costs that exceed the national average. Targeted funding to create affordable housing for people with developmental disabilities is essential for those waiting for services. Without an affordable home, clients waiting for services cannot discharge from institutional settings.

> ***On August 13, 2021, the state submitted the following:*** *Housing Trust Fund (HTF) dollars support a wide range of capital projects that house a diverse array of populations with low incomes, including those with developmental disabilities. The funds set-aside to create housing for people with developmental disabilities are issued as low-interest, fully deferred loans, payable in full, including accrued 1% simple interest, at the end of the commitment period, which is either 40 or 50 years, unless otherwise negotiated at maturity or upon change of use or sale of the property. Categorically, HTF investments are not a subsidy and do not pay for room or board. These investments expand affordable housing infrastructure for people with disabilities who receive HCBS services and help to ensure individuals long-term success in the community. The HTF set-aside creates affordable housing throughout communities in Washington State. These funds will be used for projects meeting HCBS settings requirements. Access to affordable housing is an essential component in supporting timely access to HCBS.*

Increase in home and community-based rates

Improving rates for providers, including raising wages and increasing benefits for individual providers and home care agencies improves HCBS services by assuring provider stability, especially now during a behavioral health workforce crisis with increasing needs from Medicaid clients.

Adult family home award/agreement: Funding is provided to implement new items identified in the 2021-23 collective bargaining agreement (CBA) reached between the Governor and the Adult Family Home (AFH) Council. Among other provisions, the CBA increases the hourly wage component of the AFH rate by 3 percent.

> ***On August 13, 2021, the state submitted the following:*** *The new collective bargaining agreements all contain additional funding over prior agreements for vendor rate increases to Adult Family Homes, home care agencies and Individual Providers, who are self-directed employees hired directly by consumers served in their own homes. The Adult Family Home Collective Bargaining Agreement increases the following components within the daily vendor rate: direct care wages, health care, training, and administration. The Collective Bargaining Agreement covering Individual Providers contains increases of 3% on hourly wages as well as increases for health care coverage and retirement benefits for these direct care workers. Through statute, increases appropriated through the Individual Provider CBA are converted to increases in the vendor rate for Medicaid contracted home care agencies and those additional funds must be used to increase compensation and benefits for direct care workers. Currently the biggest challenge facing the Washington's HCBS providers is recruiting and retaining a workforce of qualified caregivers. The intent of leveraging the enhanced FMAP is to maintain and expand the workforce of contracted providers who are the backbone of the state's HCBS services.*

In-home care provider agreement: Funding is provided to implement new items identified in the 2021-23 CBA reached between the Governor and Service Employees International Union (SEIU) 775, the official bargaining representative for individual providers.

Agency provider agreement parity: Funding is provided to create rate parity between agency providers and individual providers related to new items identified under the 2021-23 individual provider CBA.

Agency provider administrative rate: Funding is provided to increase the administrative rate paid to home care agencies by $0.05 per hour effective July 1, 2021.

Assisted living facility rates: Funding is provided to increase the base Medicaid daily rates for assisted living facilities to a level that covers 60 percent of costs. This is a critical and needed rate increase to support Medicaid HCBS options for people.

Specialty dementia care rate add-on: Funding is provided to increase the daily Medicaid rate paid to specialty dementia care (SDC) providers for approximately $10 per client. The SDC providers are licensed assisted living facilities under contract with DSHS to care for individuals with dementia.

COVID temporary rate increases: One-time funding is provided to continue the COVID-19 rate enhancements in effect as of June 2021 to contracted providers through December 2021. Funding is provided to address increases in staffing costs/hazard pay, training, infection control and personal protective equipment.

Enhanced community residential rate: Funding is provided to increase rates for Medicaid HCBS supported living IDD and other community residential service providers by 2 percent effective January 1, 2022, and by an additional 2 percent effective January 1, 2023.

Consumer-directed employer (CDE) vendor rate: Increased the administrative rate paid to the Medicaid IP CDE vendor.

Subminimum wage: Funding is provided for DSHS to work with employment providers to assist individuals with intellectual and development disabilities who are employed in subminimum wage jobs to transition into minimum wage employment. This is an important HCBS Medicaid service.

COVID-related investments

The state recognizes the ongoing impact of COVID-19 within the HCBS provider network. Providers continue to experience significant pandemic related costs. The necessity to implement telemedicine/telehealth technologies during the pandemic highlighted the broadband divide in our communities. The remote technology support initiative below works to close this divide and reduce the disparities experienced by clients with developmental disabilities.

Area Agency on Aging case management: One-time funding is provided to offset cost impacts associated with COVID-19 on the in-home Medicaid long-term services and supports case management program operated by Washington's 13 Area Agencies on Aging, a critical support for the HCBS Medicaid system.

Remote technology support: Funding is provided for DSHS to purchase an estimated 4,394 devices that may be distributed to clients with developmental disabilities and their contracted providers, with the purpose of helping clients and providers utilize services remotely during the COVID-19 pandemic. Targeted funding for remote technology strengthens HCBS by enhancing the connectivity of individuals who may not otherwise have access to the technology needed to engage fully in remote services.
On August 13, 2021, the state submitted the following: *Remote technology support will not be utilized to purchase ongoing internet connectivity. Remote technology support will fund the purchase of devices to be distributed to DDA clients and contracted providers, with the purpose of helping clients and providers access and deliver services remotely during the COVID-19 pandemic.*

Improved provider rates, recruitment, retention, and skills training for HCBS providers

Expanding HCBS services requires a multi-prong strategy and strengthening our provider network is a critical requirement. The initiatives in this section make investments in training, recruitment of Washington's HCSB providers. These are especially important now with growing Medicaid based community behavioral health workforce shortages and increasing patient needs to access care.

Managed care behavioral health rate increase: Funding is provided to invest in workforce supports through a 2 percent increase to Medicaid reimbursement for community behavioral health providers contracted.

MCO wraparound services: Funding is provided for Medicaid MCOs to increase provider rates by 2 percent for non-Medicaid wraparound services effective July 2021. These are critical supportive services for the Medicaid program. Without this HCBS funding the Medicaid program would fall short and people would not receive the care necessary, necessitating more expensive emergency room and institutional care.

Parent Child Assistance Providers (PCAP) rate increase: Funding is provided for a 2 percent rate increase for PCAP providers effective July 2021.

> ***On August 13, 2021, the state submitted the following:*** *Parent Child Assistance Program (PCAP) is described in full in the submittal language, see above. PCAP folds into Appendix B services under Case Management as defined under sections 1905(a)(19) and 1915(g) of the Act and 42 CFR § 440.169 and 42 CFR § 441.18, assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services.*
>
> *The adult and youth mobile crisis teams Mobile Integrated Health Pilot services fall under the rehabilitative services benefit as an optional Medicaid state plan benefit authorized at section 1905(a)(13) of the Act and codified in regulation at 42 CFR § 440.130(d) as "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level." (source: appendix b doc – (page 15))*

Caregiver/provider training: One-time funding is provided to invest in additional training for Medicaid caregivers and developmental disabilities providers. Improvements in training will strengthen the HCBS system by improving provider skills and knowledge in services to people with developmental disabilities.

Paid time off (PTO) transfer: Funding PTO for Medicaid individual providers will enhance the retention of providers. Funding for an accrued, but unpaid, obligation for earned PTO is paid to the new Consumer Directed Employer (CDE) entity that will employ individual provider home care workers within the year. This new funding is necessary to allow the CDE to pay full benefits and wages to the individual providers.

Home health social worker: Funding is provided for a social worker as part of the medical assistance home health benefit. This is a critical HCBS Medicaid service.

Substance use disorder (SUD) family navigators: Funding is provided for grants for Medicaid serving substance use disorder family navigators. Navigators will work to advance the peer workforce and increase the knowledge and skills of peer support providers in working with adults, families, and youth experiencing substance use disorder. This will include a series of online train-the-trainer events for identified peers and organizations, follow-up coaching, and technical assistance as participants move toward mastery of the content. We expect to host four cohorts this biennium.

Creating pathways to HCBS services

This plan outlines initiatives that enhance and expand HCBS services, strengthen the provider network, and broaden access for some of Washington's most vulnerable populations. The initiatives outlined in this section of the plan are investments that the state believes will build new pathways for eligible clients to access HCBS services.

Rural behavioral health pilot: Funding is provided for a one-time grant to Island County to fund a pilot program to improve behavioral health outcomes for young people in rural communities. School districts, community groups, and health care providers will coordinate to increase access to behavioral health programs for children and youth birth to 24 years old. Services that may be provided with the grant funding include, but are not limited to: Support for children and youth with significant behavioral health needs to address learning loss caused by COVID-19 and remote learning; School based behavioral health education, assessment, and brief treatment; Screening and referral of children and youth to long-term treatment services; Behavioral health supports provided by community agencies serving youth year-round; Expansion of mental health

first aid, a program designed to prepare adults who regularly interact with youth for how to help people in both crisis and noncrisis mental health situations; Peer support services; and Compensation for the incurred costs of clinical supervisors and internships.

Child assessment and diagnosis: Funding is provided to implement changes to assessment and diagnosis of children birth to 5 years old, including provision of up to five sessions for intake and assessment in their home or other natural setting. The amounts include funding for provider reimbursement for traveling to the child as well as training on application of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: DC: 0-5.

> ***On September 24, 2021, the state submitted the following:*** *The child assessment and diagnosis activities will not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021.*

Stakeholder feedback

Washington state is deeply committed to stakeholder participation at all stages of program and policy development. Throughout the pandemic, we engaged stakeholders in development of our response strategies. Special efforts were made to engage stakeholders in developing ideas for use of funds made available through the American Rescue Plan Act. The Governor's Office and the Office of Financial Management (OFM) requested funding ideas and received a substantial response from constituents around the state. The Washington State Legislature passed legislation and appropriated these items, which necessitates substantial open public processes with substantial opportunity for stakeholder and public comment. Washington state actively engaged with stakeholders using different methods. Our methods have included statewide town halls held online, request for feedback sent via email distribution lists, and engagement meetings with client and provider advocacy groups. We received feedback from individuals as well as groups, including:

- Self-advocacy groups
- Disability advocacy groups
- Provider representatives and associations
- Area Agencies on Aging
- Labor representatives

Ideas generated by stakeholders

The following are themes for how to use funding to enhance, expand or strengthen home and community-based services generated by stakeholders and collected from the engagement work, which greatly informed this spending plan:

- Workforce building enhancements and incentives
- Enhancements to provider rates and incentives
- Behavioral health crisis support in the form of mobile crisis teams
- Rental assistance
- Homeless outreach and support through program expansion and enhancements
- Chemical dependency treatment and support
- Support for unpaid family caregivers
- Training and outreach to support families and caregivers of children with complex behavioral health needs

- Purchase of technology devices, infrastructure, and pre-paid plans for clients
- Provide adult day centers with funding to make physical, operational, or other changes to safely deliver services during the COVID-19 public health emergency
- Purchase PPE and testing supplies
- Workforce training in rural areas and in tribal communities
- Develop culturally attuned educational materials in accessible formats
- Address social determinants of health and health disparities
- Support outreach to decrease social isolation

Tribal meetings

There are 29 federally recognized tribes in Washington, as well as urban Indian centers in Seattle and Spokane. Through our commitment to a government-to-government approach to seek consultation and participation by representatives of tribal governments in policy development and enhancement of programs, we have engaged tribal leaders in the process of soliciting ideas for additional HCBS enhancements. This came in the form of presentations and conversations at our agency's Indian Policy Advisory Committee meetings, the annual Centennial Accord meeting with the Governor, and direct solicitation in the form of agency communications and communications from the Governor's office and the Office of Financial Management.

We recognize that tribes are uniquely positioned to offer suggestions for program enhancements that help to elevate and address inequities in our systems to provide more culturally relevant and full-spectrum services.

Some themes that came from this engagement include:

- Workforce training in rural areas and in tribal communities
- Enhancements to provider rates and incentives
- Support for unpaid family caregivers
- Purchase of technology devices, infrastructure and pre-paid plans for clients
- Purchase PPE and testing supplies
- Support homeless elders and individuals with disabilities to receive care (this may be enhanced case management or other methods)
- Develop culturally attuned educational materials in accessible formats
- Address social determinants of health and health disparities
- Support outreach to decrease social isolation
- Rebuilding infrastructure for Tribal LTSS that suffered during the pandemic

Appendix A

Item	Total ($ in Thousands)
Behavioral Health Transitions	630
Hospital Surge- Geriatric-Specialty	548
Hospital Surge-Specialized Dementia	1,024
Hospital Surge- Non-Citizens	1,069
Rental Subsidies	3,594
Shared Benefit Adjustment	19,985
Shared Benefit Adjustment	10,088
AFH Award/Agreement	2,534
AFH Award/Agreement	405
Children's SOLA	888
ALTSA - In-Home Care Provider Agreement	4,585
DDA - In-Home Care Provider Agreement	1,986
ALTSA - Agency Provider Agreement-Parity	1,456
DDA - Agency Provider Agreement-Parity	218
ALTSA - Personal Needs Allowance	15
DDA - Personal Needs Allowance	4
High School Transition Students (PL)	560
Increase CIIBS Waiver Capacity	1,040
PASRR Capacity Increase	446
Dementia Action Collaborative	563
ALTSA - COVID Temporary Rate Increases	61,411
DDA - COVID Temporary Rate Increases	34,089
ALTSA - Agency Provider Administrative Rate	196
DDA - Agency Provider Administrative Rate	29
Enhanced Community Residential Rate	1,737
Caregiver/Provider Training	231
ALTSA - HCBS Supports	1,775
DDA - HCBS Supports	808
Increase IFS and Basic Plus Waivers	6,883
Increase Core and CP Waivers	7,609
I/DD Summer Programs	1,845
ALTSA - Assisted Living Facility Rates	453
DDA - Assisted Living Facility Rates	12
Specialty Dementia Care Rate Add-On	785
Subminimum Wage	111
Community Residential Options	995
Dan Thompson Community Investments	50,000

Item	Total ($ in Thousands)
Remote Technology Support	1,140
Peer Mentor Program	35
Conditionally Released SVPs	63
Fall Prevention Training	50
AAA Case Management	3,063
ALTSA - CDE Vendor Rate	259
Developmental Disability Services	119
DDA - CDE Vendor Rate	109
CDE PTO Transfer	9,290
Housing Trust Fund	10,000
Home Health Social Worker	232
PCAP Expansion	464
SUD Family Navigators	244
Safe Station Pilot Programs	98
Expand SUD Services and Supports	2,434
MCO Behavioral Health Rate Increase	4,811
Rural Behavioral Health Pilot	183
Trueblood Phase 2 Implementation	2,363
Child Assessment & Diagnosis	54
CLIP HMH Facility	195
Short-Term BH Housing Support	1,516
Adult and Youth Mobile Crisis Teams	6,520
MCO Wraparound Services	158
Mobile Integrated Health Pilot	183
PCAP Rate Increase	79
SUD Family Navigators	122
Outreach/Intensive Case Management	4,875
Short-Term SUD Housing Vouchers	244
Recovery Residences	37
Clubhouse Expansion	816
Homeless Outreach Stabilization	2,438
Opioid Treatment Network	244

Total	**273,045**