STATE OF WASHINGTON
HEALTH CARE AUTHORITY
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August 13, 2021

Jennifer Bowdoin
Director, Division of Community Systems Transformation
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. Bowdoin,

The State of Washington has reviewed the Center for Medicare and Medicaid Services' (CMS) request for additional information regarding Washington State's section 9817 initial spending plan and narrative. Below you will find Washington State's response to the questions posed.

We look forward to CMS' continued review of the spending plan and narrative, and will continue to update CMS on our implementation of section 9817 via quarterly 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 the opportunity and your partnership in this effort.

Sincerely,

Charissa Fotinos, MD
Interim Medicaid Director

The Centers for Medicare & Medicaid Services (CMS) requested additional information on Washington's section 9817 initial spending plan and spending narrative on July 23, 2021. This document responds to CMS' specific questions and provides information on Washington's approach and many of the initiatives highlighted in the original submittal.

The responses below are organized by CMS' July 23rd question and/request for information followed by Washington's response:

CMS' July 23rd response: Please provide an estimate of the anticipated expenditures for the activities the state intends to implement to enhance, expand, or strengthen HBCS under the state Medicaid program between April 1, 2021, and March 31, 2024.

Washington State's response: 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.

CMS' July 23rd response: The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021. Washington has assured CMS that the state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021. Please confirm that through changes to child assessment and diagnostics the state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021.

Washington State's response: 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.

CMS' July 23rd response: 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 are not directly related to the services listed in Appendix B or could be listed in Appendix B, explain how those activities expand, enhance, or strengthen HCBS under Medicaid.

Washington State's response: We believe that all behavioral health provider activities would be services that are listed in Appendix B or could be listed in Appendix B; or are 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. We believe that the specific

HCBS Medicaid Authority is found under the Rehabilitative Services and Case Management section. As the Corresponding Form 64 Claiming Line is under development, we will await further instructions.

The responses below are organized by the initiatives title and includes the originally submitted narrative, CMS' July 23rd response, and Washington's answer:

Hospital surge, non-citizens

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Provide additional information to explain how the "Hospital surge, non-citizens" activity expands, enhances, or strengthens HCBS under Medicaid.

Washington State's response: 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.

Conditionally released sexually violent predators

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Provide additional information about the anticipated outcomes of the "Conditionally released sexually violent predators" activity, including the number and percentage of individuals served who are expected to be Medicaid eligible and the number and percentage of individuals served who are expected to transition to the community as opposed to institutional care post-release.

Washington State's response: 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.

Fall prevention training

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Clearly indicate if the long-term care facilities targeted for the fall prevention training are HCBS providers, institutional providers, or both.

Washington State's response: 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.

Adult family home award/agreement

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Provide additional information about the new items identified in the 2021-23 collective bargaining agreement that will be funded under the "Adult family home award/agreement" activity, the "In-home care provider agreement" activity, and the "Agency provider agreement parity" activities.

Washington State's response: 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.

Housing Trust Fund

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Clearly indicate whether the Housing Trust Fund will be used to pay for room and board (which CMS would not find to be a permissible use of funds) and/or capital investments. If the state intends to pay for capital investments as part of this activity, CMS is not able to approve this activity at this time and will need to follow-up with the state to indicate whether this activity is approvable.

Washington State's response: 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.

Remote technology support

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Clearly indicate whether the state plans to pay for ongoing internet connectivity costs as part of the "Remote technology support" activity. If the state intends to pay for ongoing internet connectivity costs as part of this activity, CMS is not able to approve this activity at this time and will need to follow-up with the state to indicate whether this activity is approvable.

Washington State's response: 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.

Parent Child Assistance Program (PCAP) expansion

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Clarify if the services delivered under the Parent Child Assistance Program (PCAP) expansion, adult and youth mobile crisis teams, and the mobile integrated health pilot include any services other than those listed in Appendix B or that could be listed in Appendix B (e.g., behavioral health services that are covered under another benefit but could be covered under the rehabilitative services benefit). If any of these activities are not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how the activities expand, enhance, or strengthen HCBS under Medicaid.

Washington State's response: 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)).

Expand SUD services and supports

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Clearly indicate if the providers that will receive payments under the "Expand SUD services and supports" activity or under the category of "Improved provider rates, recruitment, retention, and skills training for HCBS providers" are delivering any of the services listed in Appendix B or services that could be listed in Appendix B. If the providers are not delivering services that are listed in Appendix B or could be listed in Appendix B, please explain how those payments expand, enhance, or strengthen HCBS under Medicaid.

Washington State's response: 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.

Short-term substance use disorder housing vouchers

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Provide more information about the population eligible for the "outreach or intensive case management" activity, including the percentage of participants who are expected to be Medicaid eligible and the percentage of Medicaid-eligible participants receiving the services listed in Appendix B or services that could be listed in Appendix B. If the participants are not Medicaid eligible and/or are not receiving services listed in Appendix B or that could be listed in Appendix B, explain how this activity expands, enhances, or strengthens HCBS under Medicaid.

Washington State's response: 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 need 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).

Trueblood Phase 2 implementation

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Provide additional information on the population served and the services that would be paid for under the Trueblood Phase 2 implementation, including whether the services are included in Appendix B or could be listed in Appendix B. If this activity is not directly related to the services listed in Appendix B or services that

could be listed in Appendix B, please explain how the activity expands, enhances, or strengthens HCBS under Medicaid.

Washington State's response: 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.

Children's Long-Term Inpatient Program (CLIP) habilitative mental health facility

Original ARPA spending plan narrative: 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.

CMS' July 23rd response: Indicate if the Children's Long-Term Inpatient Program (CLIP) habilitative mental health facility is an HCBS or institutional setting and/or provide additional information to explain how funding for the CLIP habilitative mental health facility expands, enhances, or strengthens HCBS under Medicaid.

Washington State's response: The CLIP HMH is an institutional setting not an HCBS.

Homeless outreach stabilization

Original ARPA spending plan narrative: 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 helps 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.

CMS' July 23rd response: Provide more information about the population eligible for the "homeless outreach stabilization" activity, including the percentage of participants who are expected to be Medicaid eligible and the percentage of Medicaid-eligible participants receiving the services in Appendix B or services that could be listed in Appendix B. If the participants are not Medicaid eligible and/or are not receiving services listed in Appendix B or that could be listed in Appendix B, explain how this activity expands, enhances, or strengthens HCBS under Medicaid.

Washington State's response: 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).

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.