STATE OF WASHINGTON

Indian Policy Advisory Committee
July 14th, 2021
Minutes

DSHS Indian Policy Advisory Committee Delegates/Alternates Represented:

Tribes/RAIOs/Departments	Delegate/Alternate/Representative
Chehalis Confederated Tribes	Francis Pickernell
Jamestown S'Klallam Tribe	Loni Greninger
Lummi Nation	Nickolaus Lewis
	Shaleena Bertram
Muckleshoot Tribe	Alexandra James
Nisqually Tribe	Marie McDonald
Nooksack Tribe	Rick George
	Ken Levinson
Port Gamble S'Klallam Tribe	Cheryl Miller
Puyallup Tribe	Mary Squally
Shoalwater Bay Tribe	Kathirine Horne
Skokomish Tribe	Denese LaClair
Stillaguamish Tribe	Jackie Roth
Tulalip Tribes	Roseann Reeves
Upper Skagit Tribe	Marilyn Scott
American Indian Community Center	Jim Sijohn
N.A.T.I.V.E. Project	Dylan Dressler
Seattle Indian Health Board	Christina Diego
	Michael Cervantes
South Puget Intertribal Planning Agency	Whitney Jones
Chief Seattle Club	Virgil Wade
DCYF	Amy Turi
HCA	Jessie Dean
DSHS	Don Clintsman
	Lisa Yanagida
	Kevin Bovenkamp
	Tim Collins
	Amy Shull
	Leah Muasau
	Janet Gone

	Aimee Gone
	Heather Hoyle
	Brenda Francis-Thomas
	Dr. Marie Natrall-Ackles
	Davida Miller
	Sharon Redmond
	Courtney Dale
	Denise Kelly
	Mary Anderson
	David Stillman
	Marietta Bobba
	Brittiny Considine
	Bill Moss
	Dorthea Dunn
	Christelle Arnett
	Chris Franks
	Lisa Vasquez
	Terry Redmon
	Saundra Cheek
	Delana Mercer
	Jim Sugden
	Michelle Martin
	Aurora Maskall
	Babs Roberts
	Amanda James
	Linda Leavell
	Jeff Flesner
	Justin Chan
	Brady Rossnagle

Opening
The DSHS Indian Policy Advisory Committee was called to order at 9:05 AM.

Loni Greninger offered a blessing.

Steve de los Angeles took roll call.

Quorum confirmed by Tim Collins.

Marilyn Scott made a comment involving the IPAC Executive Committee coordination with the American Indian Health Commission Executive Committee. She suggested we

also loop in the policy team with the Northwest Portland Area Indian Health Board since they track some of the issues in Washington, as well.

ESA Division of Child Support Workgoup
ESA staff shared that child support can affect family dynamics and how situations may vary for tribal members. Child support orders that are too high or too low can have negative impacts on families, and finding the right sized orders can improve economic and social health. Child support orders aren't currently factoring in inflation, but they should be adjustable based on life circumstances.

ESA is focused on helping parents deal with the child welfare system, substance abuse, and incarceration. They seek to support both custodial and non-custodial parents. They're working to sustain parental engagement because the process can be complicated to navigate.

- Nickolaus Lewis shared that he, as someone who pays child support, has struggled with some state processes. Child support costs have caused debt-to-income ratio issues while applying for a home loan. He has lost out on government assistance during the COVID pandemic because he wanted the children's mother to be able to claim the kids on her taxes as a cordial gesture, which caused her to reap a large sum on top of the child support he was paying, while he received nothing. He also sent their mother additional funds through a third party app to help with expenses that needed immediate assistance that the state system would have taken too much processing time with, and since he didn't submit this payment through the state system it's categorized as a gift that he doesn't get credit for. He feels that parents who are trying to do everything right and attempting to go above and beyond are having to jump through hoops and find creative solutions to these issues.
- Ken Levinson shared that he feels one of the benefits of Nooksack Child Support is that their members are taken care of within their community, which may aid in preventing situations like Nickolaus's because they have more time to work with the smaller number of individuals. Even if they're not working a case, they can help advocate for someone navigating the state system, as well.
- Marie Natrall-Ackles asked how the state helps people with developmental disabilities and how they work with them. ESA shared that in those cases there is a consent form which can be utilized to appoint a representative or person of your choice to join you in conversations with the division about your case, and you have an opportunity to join in the discussions and day-to-day operations. They also have a protection in their administrative hearings realm; if someone feels like they need some assistance in handling the hearing or modification process, in which they can request to have representation due to an inability to fully comprehend what those proceedings are doing.

Questions posed to IPAC moving forward:

1. Are there tribes whose courts or child support programs assist with “right sizing” orders?
    a. Loni Greninger shared that Jamestown doesn’t have a specific child support program because of their tribe’s size, so at this point they lean on the state for those services. That being said, they would be willing to assist with advocacy.
    b. Kathirine Horne shared that Shoalwater Bay uses the state’s child support services and that they have been extremely satisfied with their assistance thus far.
    c. Marilyn Scott from Upper Skagit said that they do not have their own program, but they do have an agreement in the region with the TANF program working with their families. Prior to the pandemic, tribal liaisons within their region would come out and work on the reservation. They could pull up child support orders in place with state and in some cases modify the order based on the circumstance of the non-custodial parent and the family situation.
2. Are any tribes interested in participating with DCS and other partners/stakeholders in developing better communications/culturally informative materials/processes for customers?
    a. ESA requests tribal input
    b. One idea was the implementation of “natural helpers” within tribal communities to link individual members with representatives from child support to help bridge the gap surrounding trust issues between tribes and state representatives.
    c. Moving forward it was decided that Chris Franks and Tim Collins would review existing internal DSHS templates and modify them to be culturally appropriate for tribes.

TLSSC Continuing Efforts

Loni Greninger discussed TLSSC meeting structure in regard to charter vs. bylaw formatting. The governor’s office suggested moving to a charter structure over bylaws. A task involves confirming that operating as a charter under the Centennial Accord will exempt the gatherings from the Public Meetings Act. She is looking to get the draft language solidified for the charter at the next sub-workgroup meeting in July or August (Vicki Lowe will draft the bill language and provide it to the sub-workgroup).
The next step will be to get the charter itself approved at the Centennial Accord pre-meeting for social services, or at the Centennial Accord itself. Then we’ll look to legislature for funding and staff support. This topic may also be discussed at the January IPAC meeting.

Department of Corrections’ Future Pathway

Nancy Dufraine shared that they are standing up the DCYF TLSSC Justice Workgroup, which will focus on topics surrounding justice issues and reform. Their first meeting is

tentatively scheduled for September 8th, with the agenda to be provided at a later time closer to the meeting date.

Jeremy Barclay spoke to the potential for unit consolidation and possible eventual closure. This discussion is in the beginning phases and they are taking the lowest impact approaches possible, such as consolidations within existing facilities. Taking units that are half full and combining them with others, for example.

Tribal Grants Program Manager Nan Benally from the American Probation and Patrol Association out of Lexington Kentucky was a guest speaker and shared that her organization will be providing Tribal Intergovernmental Reentry Workshops within the next year, most likely in 2022. In preparation for the workshop, DOC Tribal Relations will assist in contacting tribes to help set up group interviews to hear from the tribes what their general or specific needs are to best tailor the workshop to the needs of Washington State Tribes.

Adjournment

Meeting was adjourned at 11:36am by Loni Greninger.

The next IPAC meeting is scheduled for January 12th, 2022.

TLSSC Update to IPAC

July 14, 2021

Last meeting was June 10, 2021

Should TLSSC use a Charter vs. By-Laws?
GOV's Office asked TLSSC Workgroup to explore this idea. JT Austin, GOV's Office for Natural Resources and Justin Parker, Director of NW Indian Fish Commission were invited to discuss how Tribes and Natural Resource Agencies/GOV's Office interact; structure is a draft 2008 Charter.

Recent climate legislation is leading to a statewide tribal-state meeting in August to discuss tribal-state relations.

Workgroup likes the Charter idea as it was a summarized version of the by-laws.

Note: If we operate under the Centennial Accord like NR, that seems to resolve the issue of avoiding the Open Public Meetings Act.

Note: Successful advisory bodies have an organization that helps track issues and keep momentum going (i.e., NWIFC for NR, AIHC for Health). Need to find a potential organization.

Next steps:

- Schedule a next workgroup meeting for July or August to solidify draft language within the TLSSC Charter.
- Seek confirmation that charter under Centennial Accord is exempt from OPMA.
- Seek approval from TLSSC at Centennial Accord Pre-Meeting and/or Accord Meeting.
- Legislature to solidify the TLSSC, funding, and staffing support; will be looking for sponsors. Draft language will start with GIHAC language and be modified. Vicki Lowe, AIHC, to modify first draft.

Department of Social and Health Services
Indian Policy Advisory Committee
July 14, 2021 Agenda
9:00 a.m. – 11:30 a.m.

Join Zoom Meeting
https://dshs-wa.zoom.us/j/83775364876?pwd=YlZPUGpaVzhsZVdtd2FjWkxMOFlsQT09

Meeting ID: 837 7536 4876
Passcode: 100684
One tap mobile
+12532158782,,83775364876#,,,,*100684# US (Tacoma)

9:00 a.m.	Welcome and Blessing *Don Clintsman, DSHS Acting Secretary* *Loni Greninger, IPAC Chair, Jamestown Tribe Vice-Chairwoman*
9:15 a.m.	Introductions
9:25 a.m.	Roll Call
9:30 a.m.	ESA Division of Child Support – Right Sizing Child Support Orders workgroup and discussion
10:30 a.m.	TLSSC Continuing Efforts
11:00 a.m.	Department of Corrections' Future Pathway
11:30 a.m.	Adjourn

Next IPAC meeting January 12, 2022

Aging and Long-Term Support Administration

Bills that passed the 2021 Legislature

ALTSA request legislation that passed this session:

1. **SSB 5258, Consumer Directed Employer.** ALTSA request legislation. During the 2018 legislative session the Legislature passed Engrossed Substitute Senate Bill 6199 which directed DSHS to implement a vendor to perform Consumer Directed Employer (CDE) services. These are services the department takes on today including contracting, background checks, and administrative functions of hiring and terminating individual providers who provide personal care to individuals in their own homes.

   There are some things that need to be clarified in the statute and so this request package:
   - Clearly outlines the voting procedures of the CDE Rate Setting Board.
   - Documents how IP paid time off benefits will be addressed.
   - Provides a way for the CDE rate to be adjusted for changes to identified components and required federal or state rule outside of the even-numbered year cycle.
   - Documents that the CDE does not need to be certified or licensed and identifies when the transition will be initiated.

2. **ESHB 1120 - COVID-19**. ALTSA request legislation in response to the COVID-19 outbreak to address nursing home and community setting inspections, minimum staffing standards, and staff training requirements that were waived under Governor Proclamation 20-10, 20-18, 20-37, and extensions to those proclamations.

   This bill:
   - Gives the Department flexibility to develop temporary policies in a state of emergency to allow homes to admit residents with special needs related to mental illness, dementia, or a developmental disability when the staff have not completed specialty training.
   - Authorizes rule-making to address long-term care worker training and certification, and fingerprint checks as well as facility licensing requirements in a state of emergency.
   - Allows the Department to amend licensing statutes to focus on infection prevention and containment during a state of emergency and provides for rule making authority to establish a post-emergency recovery plan for inspections.
   - Provides flexibility to address staffing challenges in nursing facilities during a state of emergency.
   - Amendments would be retroactive to February 29, 2020 to include response to the continuing COVID-19 outbreak.

Other bills of interest that passed this session:

HB 1323 - Concerning the long-term services and supports trust program: Governor signed on April 21, 2021
https://app.leg.wa.gov/billsummary?BillNumber=1323&Initiative=false&Year=2021

NEW SECTION. Sec. 7. A new section is added to chapter 50B.04 RCW to read as follows: A federally recognized tribe may elect coverage under RCW 50B.04.080. If a federally recognized tribe has elected coverage under this section, it must also have the option to opt out at any time for any reason it deems necessary. The employment security department shall adopt rules to implement this section.

HB 1411 Expanding health care workforce eligibility and background checks: (here are just a few items from the legislation)

https://app.leg.wa.gov/billsummary?BillNumber=1411&Year=2021&Initiative=False.

Where the department is required to screen a long-term care 11 worker, contracted provider, or licensee through a background check 12 to determine whether the person has a history that would disqualify 13 the person from having unsupervised access to, working with, or 14 providing supervision, care, or treatment to vulnerable adults or 15 children, the department may not automatically disqualify a person on 16 the basis of a criminal record that includes a conviction of any of 17 the following crimes once the specified amount of time has passed for the particular crime:

(a) Selling marijuana to a person under RCW 69.50.401 after three years or more have passed between the most recent conviction and the date the background check is processed;

(b) Theft in the first degree under RCW 9A.56.030 after 10 years 2 or more have passed between the most recent conviction and the date the background check is processed;

(c) Robbery in the second degree under RCW 9A.56.210 after five 5 years or more have passed between the most recent conviction and the date the background check is processed;

(d) Extortion in the second degree under RCW 9A.56.130 after five years or more have passed between the most recent conviction and the date the background check is processed;

(e) Assault in the second degree under RCW 9A.36.021 after five years or more have passed between the most recent conviction and the date the background check is processed; and

(f) Assault in the third degree under RCW 9A.36.031 after five years or more have passed between the most recent conviction and the date the background check is processed.

The department shall facilitate a work group dedicated to 25 expanding the long-term care workforce while continuing to recognize the importance of protecting vulnerable adults, racial equity in client choice, just compensation for unpaid care work while preserving choice for those who wish to be informal caregivers without pay, and paid services. The work group shall identify recommendations on informed choice through a process by which older adults and people with disabilities may hire a trusted individual with a criminal record that would otherwise disqualify the person from providing paid home care services under this chapter. Two representatives, one from the west side of the Cascade mountains and one from the east side of the Cascade mountains, from federally recognized tribes;

HB 1218 Improving health, safety, and quality of life for residents in long-term care facilities:

https://app.leg.wa.gov/billsummary?BillNumber=1218&Year=2021&Initiative=false

HB 1297 Concerning working families tax exemption:

https://app.leg.wa.gov/billsummary?BillNumber=1297&Initiative=false&Year=2021

SB 5096 Concerning an excise tax on gains from the sale or exchange of certain capital assets:

https://app.leg.wa.gov/billsummary?BillNumber=5096&Initiative=false&Year=2021

SB 5399 Concerning the creation of a universal health care commission:

https://app.leg.wa.gov/billsummary?BillNumber=5399&Initiative=false&Year=2021

SB 5229 Concerning health equity continuing education for health care professionals:

https://app.leg.wa.gov/billsummary?BillNumber=5229&Initiative=false&Year=2021

SB 5476 Responding to the State v. Blake decision by addressing justice system responses and behavioral health

prevention, treatment, and related services:
https://app.leg.wa.gov/billsummary?BillNumber=5476&Initiative=false&Year=2021

HB 1372 Replacing the Marcus Whitman statue in the national statuary hall collection with a statue of Billy Frank Jr:
https://app.leg.wa.gov/billsummary?BillNumber=1372&Initiative=false&Year=2021

There were also a number of police accountability bills and environmental bills that may be of interest:
Police accountability bills that passed: HB 1267, SB 5051, HB 1054, HB 1310, SB 5066, SB 5259
Environmental bills that passed: SB 5126, HB 1091, HB 1168

- **Health Homes - HCA Tribal Affairs:** The Health Homes program integrates care within existing systems for high-risk, high-cost adults and children, including clients who are dually eligible for Medicare and Medicaid. Funding is provided to expand Health Home services to the American Indian (AI) and Alaska Native (AN) populations.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, WA 98504-5050

May 20, 2021

Dear Tribal Leader,

On May 18, Governor Inslee signed the 2021-2023 biennial budget into law. We were pleased to see that the Governor continues to support our top priorities to fund critical and emergent COVID-19 recovery activities; nursing facility rates; ongoing behavioral health transition work; and support for managed care plan personal care services. As I mentioned when we released the conference budget message, we are relieved to see a better economic outlook than we anticipated when we put forward initial requests back in December.

A significant development from Tuesday's budget signing is the veto of Section 738. Within section 738, the Legislature directed OFM to put spending of nearly $143 million toward expanding Home and Community Based Services (HCBS) by leveraging a year of additional enhanced federal Medicaid matching funds. However, because the federal government did not provide guidance regarding extending the timeline for spending these funds until May 13, 2021 (3 days after the deadline indicated in the budget proviso), the Governor's office and OFM consulted with the Legislature, and the Governor used a veto to eliminate this provision when he signed the operating budget. This will enable the Legislature to decide how the funds should be used in the supplemental budget next session and gives more time for thoughtful consideration to be put toward the use of these funds.

This veto does not have any impact on the funds themselves, the need to spend these funds, or the need to make a plan for the expenditure. It also does not lessen the need for the feedback that tribes have provided throughout this process or your involvement going forward. OFM will still begin working on a spending plan and recommendations for these funds to provide to the Legislature prior to next session.

Highlights from the Governor's 2021-23 biennial budget that impact ALTSA include:

- **Nursing Home Rates** – Rebase Medicaid nursing home rates in FY22 and add one-time funding FY23 to increase direct care rates. ($54.9M total funds; $26.8M GF-State)
- **Temporary Medicaid Provider Rate Increases** – Through December 2021, current rate add-ons remain in effect. ($142.8M; $41.1M GF-State)
- **Assisted Living Facility (ALF) Rates** – Increased funding in rate model. ($4.3M total funds; $2.0M GF-State)
- **Specialty Dementia Rate Add-on** - Increases the daily Medicaid rate paid to Specialty Dementia Care (SDC) ALF providers by approximately $10 per client. ($6.0M total funds; $2.4M GF-State)

- **Medicaid Provider Collective Bargaining:** Multiple bargaining agreements have been funded:
    - **SEIU 775 –** Representing Individual Provider homecare workers. ($63.1M Total Funds; $25.9M GF-State)
    - **Homecare Agencies –** Parity with Individual Providers. ($20.4M Total Funds; $8.4M GF-State)
    - **Adult Family Home Council –** Representing AFH owners. ($20.9M Total Funds; $8.9M GF-State)

- **AAA Case Management** - One-time funding is provided to offset cost impacts associated with COVID-19 on the in-home Medicaid long-term care case management program operated by Area Agencies on Aging. ($7.6M total funds: $3.1M GF-State)

- **Hospital Surge** to create capacity in acute care hospitals consisting of 65 Geriatric Specialty beds; 120 Specialized Dementia beds; and 20 more Non-Citizen slots. ($19.9M total funds; $13.4M GF-State)

- **Transitional Care Center of Seattle** - One-time funding through the 2021-23 biennium is provided for nursing home services and building maintenance at the Transitional Care Center of Seattle. As part of the COVID-19 response, the Department purchased this building to provide care for difficult-to-place residents from acute care hospitals, creating more hospital capacity to treat COVID-19 patients. ($46.2M total funds; $22.3 GF-State)

- **Behavioral Health Transitions** – Beginning in January 2022, 60 specialized dementia placements and 30 Enhanced Adult Residential Care placements for people transitioning from state and local psychiatric hospitals. ($14.6M total funds; $7.0M GF-State; 7.9 FTE)

- **Behavioral Health Personal Care** - Funding is provided for behavioral health personal care (BHPC) for Medicaid managed care organizations for individuals with exceptional care needs due to their psychiatric diagnosis. ($14.0M total funds; $13.6M GF-State)

- **Consumer Directed Employer** – Restored previous reduction, funded updated vendor rate, adjusted for revised implementation schedule and funded a one-time buyout of Individual Provider paid time off. ($9.1M total funds; $1.6M GF-State; 5.4 FTE)

- **LTSS Trust Infrastructure** – The Long-Term Services and Supports (LTSS) Trust Program is designed to offer a long-term care benefit to eligible individuals who require assistance with activities of daily living pursuant to Chapter 363 , Laws of 2019 (2SHB 1087). Appropriation authority from the LTSS Trust dedicated account is provided for the Department to prepare and implement the new program. ($8.1M total funds; 12.5 FTE)

As always, thank you for the work you do to continue to support individuals in Washington who are in need of long-term services and supports. For additional details on the biennial budget, click here.

ALTSA Strategic Plan 2021-2023: https://www.dshs.wa.gov/altsa/about-us

All strategic plan goals support improving long-term services and supports for all residents in Washington State. There are also specific goals related to work with Tribes.

Strategic Objective 1.3: WA Cares Fund – Conduct planning and outreach activities for implementation of the Long-Term Services and Supports Trust Act which will deliver benefits to eligible individuals beginning January 2025.
Decision Package: 050 – PL – ES – LTSS Trust Staff/Infrastructure This funding will be allocated for the establishment and launch of the Long-Term Services and Support Trust program. Funding will used towards policy formation, IT system creation and support, public outreach, network development and LTSS Trust Commission support.
Importance: Long-term care is not covered by Medicare or other health insurance plans, and the few private long-term care insurance plans that exist are unaffordable for most people. More than 90 percent of seniors are uninsured for long-term care. Approximately 70 percent of individuals who reach age 65 will need long-term care in their lifetimes. Many of those individuals will have to spend down savings to qualify for Medicaid in order to get the care they need. Providing another method for funding long-term care will relieve hardship on families and lower the increasing burden of Medicaid costs on the state budget. ALTSA has a significant role in the planning and implementation of the Trust Act.
Success Measure 1.3.2: Tribes/Tribal Enterprises will have an opt-in option to the WA CARES Fund by June 2023. Action Plan:

- The ALTSA Tribal Affairs Office and the DSHS Office of Indian Policy (OIP) will work with the WA CARES Fund staff and tribes/tribal enterprises/tribal organizations to implement a tribal opt-in provision.
- ALTSA staff and DSHS OIP will coordinate with the Indian Policy Advisory Committee/subcommittee, the Tribal Leaders Social Services Council (TLSSC), the Governor's Office of Indian Affairs, the Health Care Authority and the Employment Security Department to implement LTSS Commission and tribal recommendations from 2021 workgroups.
- ALTSA staff and DSHS OIP will coordinate with the Indian Policy Advisory Committee/subcommittee, the TLSSC, the Governor's Office of Indian Affairs, the Health Care Authority and the Employment Security Department to look at other issues or considerations as found by tribes and tribal enterprises (page 8).

Strategic Objective 2.13: Tribal Affairs – Continue to build strong relationships with, and expand contract opportunities for, tribes/tribal organizations to increase access to culturally attuned long-term services and supports for American Indians/Alaska Natives (AI/AN) to age in their homes or community-based settings of their choice.
Importance: ALTSA continues to focus on strengthening government-to-government relationships with tribes, decreasing barriers to accessing services and advancing culturally attuned services, providers and programs. We will continue to work with tribal organizations to: 1) delay or prevent institutional placement for AI/ANs; 2) identify AI/ANs who are living in institutions and assist them to return to their community of choice; and 3) develop culturally attuned service systems and providers to support AI/ANs once they return to their

communities. Work will focus on developing service contracts and engaging potential partners at the state, tribal and county levels for improved and culturally attuned service delivery of long-term services and supports.
Success Measure 2.13.1: Procure and sign at least three contracts to benefit AI/AN elders, veterans and adults with disabilities by June 2023.
Action Plan:
• ALTSA will engage tribes and tribal organizations to expand information and identify opportunities for the delivery of long-term services and supports to AI/ANs.
• ALTSA will build state agency partnerships (Department of Commerce, Health Care Authority, etc.) to identify complementary funding resources and opportunities for tribal contracting that support elders and individuals with disabilities and provide comprehensive, evolving long-term services and supports with mindfulness to the barriers.
• ALTSA will build strong relationships with long-term service providers to assist with increasing statewide capacity to serve AI/AN older adults and individuals with disabilities during the COVID-19 pandemic and throughout the recovery period.
Success Measure 2.13.2: Identify and implement increased federal financial participation for a minimum of one long-term services and supports contract provided by June 2023.
Action Plan:
• ALTSA will engage tribes to identify long-term services and supports that meet the federal requirements for increased federal financial participation.
• ALTSA will share federal requirements for Indian Health Service contract language updates to help tribal social and health service departments bill for Medicaid-reimbursed long-term services and supports at optimum reimbursement levels.
• ALTSA will develop and implement billing guidelines and systems for Medicaid reimbursed long-term services and supports provided by Tribal Governments/Enterprises in coordination with the Health Care Authority. (page 18-19)

Strategic Objective 3.5: Promote equity, diversity, and inclusion (EDI) practices.
Importance: ALTSA recognizes the relevance of understanding and practicing EDI principles in the delivery of long-term services and supports. Creating and maintaining a work and service delivery environment that recognizes, values, supports and embraces respect for individual differences is important to supporting the administration's vision and to providing equal and culturally competent access to populations that may otherwise be left out or not appropriately or fully served. In order to create and maintain such a workplace culture and service delivery system, ALTSA understands the benefits of integrating equity (fairness), diversity (difference) and inclusion (participative voice) in all areas of its business.

To achieve this goal, support for EDI must start with leadership. ALTSA is committed to building an infrastructure of EDI principles that includes a shared understanding throughout the administration of the benefits of a diverse workforce. Having a diverse workforce can help ALTSA better meet the needs of the people we serve every day. By having certified diversity professionals and executives throughout the νν DSHS | Aging and Long-Term Support Administration P a g e |24 administration, the principles of fairness, difference and participative

voice will be understood in a manner that reinforces that EDI is not something we do, but is, in fact, who we are. ALTSA recognizes the need to address the ongoing effects of systemic racism on staff and clients. In doing so, ALTSA is committed to better education of leadership and staff members about race and how to practice antiracism. Only by first looking inward and working on ourselves can we truly be committed to providing the highest quality services for the clients we serve.

Success Measure 3.5.1: Provide fundamentals of EDI, to include anti-racism training to ALTSA management and staff by December 2022.

Action Plan:

- ALTSA will continue training staff about EDI principles.
- ALTSA will expand Quality Assurance policies and procedures to measure success.
- ALTSA will continue to expand on Certified Diversity Executive/Certified Diversity Professional (CDE/CDP) learning throughout the administration.

Success Measure 3.5.2: Operationalize EDI principles throughout the organization, as measured by completion of the Action Plan by December 2022.

Action Plan:

- ALTSA will meet or exceed the Culturally and Linguistically Appropriate Services (CLAS) Standards. We will be proactive in supporting a diverse workforce across the administration. We will create and support programs to help retain staff. We will examine institutional practices and policies and remove any potential biases identified within those policies and procedures.
- ALTSA will provide opportunities for staff and leadership to acquire shared language and practices on equity through diversity workshops (regional), discussion opportunities and resource sharing on EDI topics that engage the entire workforce. ALTSA will build on recognized milestones of equity, diversity and inclusion with the additional EQUITY TOOLS of truth, social justice and dismantling racism to advance our progress in removing obsolete structures to create more productive practices and a more inclusive workplace.
- ALTSA will work with tribes and ALTSA EDI to identify barriers and unintended consequences of hidden bias in current practices. Page 23-24)

Washington State Department of Social & Health Services
Transforming lives

Behavioral Health Administration Budget

Where are we in the budget process?

On April 25, the legislature released the 2021-23 operating and capital budgets to Governor Inslee for signature. Governor Inslee signed ESSB 5092 in to law on May 18, 2021 with partial vetoes.

2021-23 Enacted Capital Budget Summary

- $51 million for design of a new 350-bed forensic hospital at WSH
- $52.9 million for a 16-bed Behavioral Health Residential Treatment Facility at Maple Lane and a similar 48-bed facility in Clark County
- $5 million to remodel the Columbia Cottage at Maple Lane to accommodate NGRI patients
- $6 million for site selection and design for a new Secure Community Transition Facility in Snohomish County for SCC
- $1.6 million for a Low Stimulation Addition at the CSTC

2021-23 Enacted Operating Budget Summary

- $56 million reduction for the closure of six civil wards at WSH
- $27.4 million to open two new 29-bed competency restoration wards at WSH
- $17.4 million to operate two new 16-bed civil residential treatment facilities
- $4.3 million to fully support operation of two forensic wards at ESH
- $539,000 to support program needs at CSTC
- $210,000 to operate new Low Stimulus Area at CSTC
- $3.2 million for Forensic Navigator Program to expand in to King County
- $3.2 million to support Trueblood infrastructure and reporting requirements
- $2.2 million for medical staff and equipment at SCC
- $13.4 million to implement ESSB 5163, which requires SCC to lead resident’s discharge planning

Aging and Long-Term Support Administration

Aging and Long-Term Support Adminstration

Indian Policy Advisory Committee Quarterly Update July 2021

Transforming Lives

Handouts:

1. State Legislative Session
    a. DSHS ALTSA Final Biennial Budget Release -Tribal Leader Communication
    b. Bills of Interest that Passed the 2021 Session (please review and update if needed).
2. ALTSA 2021-2023 Strategic Plan
    a. Tribal Leader Communication
    b. Specific ALTSA goals pertaining to working with tribes

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 98504-5600

June 17, 2021

Dear Tribal Leader,

We are pleased to announce the release of our updated 2021-2023 Aging and Long-Term Support Administration (ALTSA) Strategic Plan, located on our website at: https://www.dshs.wa.gov/altsa/about-us

RCW 43.88.090 directs each state agency to define its mission and to establish measurable goals to achieve desirable results for customers, and to develop clear strategies and timelines for achieving these goals. Guidelines for state agencies to follow when developing strategic plans are released by the Office of Financial Management (OFM) each biennium.

The Strategic Plan is a living document that undergoes a regular cycle of updates. If you have suggestions for improvements to ALTSA's Strategic Plan, please contact Kristi Knudsen at kristi.knudsen@dshs.wa.gov.

Thank you for the work you do in supporting individuals in need in Washington State.

Sincerely,

Bill Moss
Assistant Secretary
Aging and Long-Term Support Administration

DSHS: *Transforming Lives*

Washington State Department of Social & Health Services

Transforming lives

Developmental Disabilities Administration

IPAC July 2021

Executive Summary: Debbie Roberts is DDA’s new Assistant Secretary. CMS provides guidance for the estimated additional $1.5 billion from enhanced Federal Medical Assistance Percentage (FMAP).

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Developmental Disabilities Administration Indian Policy Advisory Committee

Overview of Programs and Services

Each year more than 4,600 Developmental Disabilities Administration (DDA) employees provide services and supports for more than 49,000 clients with developmental and intellectual disabilities.

2018 Canoe Journey

The DDA biennial budget for fiscal year 2021-2023 is $4.3 billion.
As of July 1, 2021, 461 clients self-identify with tribal affiliation.
DDA offers a continuum of safe, high quality supports such as:

- Case management
- Community residential services
- Employment, day, and community services
- Home and Community Based Service waivers
- Community First Choice
- Person-centered service planning

For more information about programs and services, see the 2020 Developmental Disabilities Administration Caseload and Cost Report.

Debbie Roberts
Assistant Secretary
(360) 407-1564
Debbie.Roberts@dshs.wa.gov
https://www.dshs.wa.gov/dda/

July 1, 2021

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Developmental Disabilities Administration
PO Box 45310, Olympia, WA 98504-5310

May 28, 2021

Dear Tribal Leader:

DSHS Secretary Cheryl Strange announced the appointment of a senior leadership position to the agency's Developmental Disabilities Administration. The new appointment follows the January announcement that Evelyn Perez, assistant secretary for DDA since 2013, retired at the end of April.

"I am grateful to Evelyn for all of her hard work and tremendous leadership—she has truly earned her retirement," said Strange. "Evelyn dedicated 35 years of public service to DSHS and the people of Washington state. Many have benefitted from her contributions and work in informing person-centered supports and services."

As of May 1, Debbie Roberts, the previous deputy assistant secretary for DDA, serves as DDA's new assistant secretary. Roberts originally joined DSHS in 1986. She began serving the developmental disabilities population in 1985 and became the deputy assistant secretary in 2018.

She holds a bachelor's degree in psychology from the University of Puget Sound and has held several leadership positions throughout her career.

"Debbie's extensive knowledge of programs and services, combined with her ability to lead teams of professionals in meeting strategic objectives will be a tremendous asset to DDA," said Strange. "She brings forward thinking and a proven track record of fostering community partnerships which empower the people DDA serves to live the independent lives they want."

In June, Gov. Inslee honored Roberts with the Governor's Award for Leadership in Management. Her nomination spoke of her many talents and read in part, "Roberts embodies the image of performance-based leadership by empowering her staff, improving their work environment and improving the lives of our clients."

"DSHS' Developmental Disabilities Administration provides services to approximately 35,000 clients with a $3.8 billion budget, "added Strange. "I am excited to see DDA flourish under Debbie's leadership."

Assistant Secretary Roberts is committed to working with tribal governments on a government-to-government basis and strongly supports and respects tribal sovereignty and self-determination for tribal governments. She acknowledges and reaffirms the existence and durability of our unique government-to-government relationship.

We thank you for the work you do each day to provide supports and foster partnerships that empower people to live the lives they want.

Sincerely,

Debbie Roberts, Assistant Secretary

cc: Tim Collins, Senior Director, Office of Indian Policy
Shannon Manion, Deputy Assistant Secretary, DDA
Tonik Joseph, Director of Strategic Planning & Quality Compliance Monitoring, DDA
Justin Chan, Equity, Diversity and Inclusion Administrator and Tribal Liaison, DDA

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Developmental Disabilities Administration
PO Box 45310, Olympia, WA 98504-5310

May 28, 2021

Dear Tribal Leader:

On May 18, Governor Inslee signed the 2021-2023 biennial budget (Senate Bill 5092) into law. We are pleased to see the governor's continued support for services and supports for individuals with developmental and intellectual disabilities.

The governor vetoed Section 738 of SB 5092 that directed the Office of Financial Management to spend nearly $143 million toward expanding Home and Community Based Services by leveraging a year of additional enhanced federal Medicaid matching funds. The federal government did not provide guidance on timeline extensions. The veto will enable the 2022 state legislature to decide how the funds should be used.

I am pleased to provide the 2021-2023 biennial budget highlights below:

- **Increased capacity in each of DDA's five waivers** - Funding is provided to add 923 slots on the Individual and Family Services waiver, 100 slots for Children's In-Home Intensive Behavioral Supports, 467 slots for the Basic Plus waiver, three slots to Community Protection waiver, and 159 slots for the Core waiver. ($67.2M total funds; $30.9M GF-State; 37.4 FTE)

- **Remote Technology Support** - Funding is provided for DDA to purchase approximately 4,394 devices to distribute to DDA clients and contracted providers, to help them utilize services remotely during the COVID-19 pandemic. ($3.8M total funds; $1.5M GF-State)

- **Child Welfare for DD Foster Care Youth** - Funding is provided to implement Second Substitute House Bill 1061 (child welfare/developmental disability), which adds a shared planning meeting for dependent youth who may be eligible for DDA services after transitioning to adulthood. ($1.3M total funds; $824,000 GF-State; 5.7 FTE)

- **Children's State-Operated Living Alternative (SOLA) homes** – Funding and staffing are provided for four new homes to serve a total of 12 children and youth age 20 and younger by June 2023. ($9.7M total funds; $4.6M GF-State; 46.8 FTE)

- **Dan Thompson Community Investments** – State funds offset by receipt of the enhanced federal match through the American Rescue Plan Act will be reinvested one-time in community services for those with intellectual and developmental disabilities. ($50M total funds)

- **Medicaid Provider Collective Bargaining:** Multiple bargaining agreements have been funded:

  - **SEIU 775 –** Representing Individual Provider homecare workers. ($28.3M total funds; $11.6M GF-State)
  - **Homecare Agencies –** Parity with Individual Providers. ($3.1M Total Funds; $1.3M GF-State)
  - **Adult Family Home Council –** Representing AFH owners. ($3.3M Total Funds; $1.4M GF-State)

- **Temporary Provider Rate Increases** - through December 2021, current rate add-ons remain in effect. ($65.1M total funds; $18.7M GF-State)
- **Enhance Community Residential Rate** – Rates for supported living and other community residential service providers are increased by 2% effective January 1, 2022, and by an additional 2% effective January 1, 2023. ($30.2M total funds; $14.9M GF-State)
- **PASRR Capacity Increase** - Pre-admission Screening and Resident Review services are an entitlement for individuals with intellectual or developmental disabilities in nursing facilities. A current and projected increase in the caseload and per capita costs is in the budget. ($4.3M total funds; $1.8M GF-State)
- **Community Residential Options** – Additional five, three-bedroom SOLA homes for adults; 12 additional clients in contracted supported living settings; and four beds in Adult Family Homes to expand community residential options for those with intellectual and developmental disabilities by the end of June 2023. ($10.3M total funds; $4.8M GF-State; 47.5 FTE)
- **Field Staff Vacancies** - Through FY 2021, staff hiring has not kept pace with budget additions. As a result, ongoing funding and staffing reductions made in the 2021 supplemental budget to align more closely with actual experience are continued. (-$5.9M total funds; -$2.9M GF-State; -30.9 FTE)
- **Fircrest Nursing Facility** - The design of a new 120-bed nursing facility on the Fircrest campus is funded as preparation for future construction. ($7.8M GF-State)
- **Residential Habilitation Center Fire Alarms** - New fire alarms at Rainier and Fircrest schools (as well as Western State Hospital). ($5.0M GF-State)

Thank you for everything you do.

If you have questions regarding the 2021-2023 biennial budget or other results of the legislative session, please contact Luisa Parada Estrada by emailing paradla@dshs.wa.gov.

Sincerely,

Debbie Roberts
Assistant Secretary, Developmental Disabilities Administration
DSHS: *Transforming Lives*

Washington State Department of Social & Health Services

Transforming lives

Background Check 2021
Frequently Asked Questions: DDA Background Checks

Q: What are the legislative changes happening this year for Background checks?

A: House Bill 1411 Passed in the 2021 legislative session effective 7/2021:

- Time limiting some previously permanently Disqualifying crimes:
  - Selling drug paraphernalia – 3 years
  - Selling marijuana to ~~someone under 21~~ a person – 3 years
  - Theft in the 1st degree –-10 years
  - Extortion in the 2nd degree – 5 years
  - Assault in the 2nd degree – 5 years
  - Assault in the 3rd degree – 5 years

- Established a stakeholder workgroup to identify and informed choice process allowing older adults and people with disabilities to hire an individual with a disqualifying criminal record.

- Authorizes the Department to perform a Character Competency and Suitability review for applicants that have obtained a Certificate of Restoration of Opportunity from the Washington state courts.

Q: When is the new Fingerprint Vendor, Fieldprint starting?

A: Due to delays the start date will not be July 2021, Idemia will continue for the next year and BCCU will give 45 days notice before the new start date.

Q: How can I find out more information about Certificates of Parental improvement or CPI?

A: Certificates of Parental Improvement removes barriers to employment for individuals with a founded finding of child abuse or neglect.

- The Department of Children, Youth & Families (DCYF) has more information on their website Certificates of Parental Improvement.

Q: What should I do about all the Fingerprints pending due to the Public Health Emergency (PHE)?

A: All applicants with a Fingerprint in pending status due to the PHE should make a Fingerprint appointment immediately.

Q: What advice can I give to applicants with a disqualifying crime on their background check?

A: DDA cannot provide legal advice, but has compiled several resources that may help address stakeholder concerns regarding disqualifying criminal history. If you have specific questions or legal concerns, consult an attorney. The resources to help address concerns follow:

- The Washington State Courts - House Bill 1041 or the "New Hope Act," was passed by the Washington State Legislature in 2019. It promotes successful re-entry by modifying the process for obtaining certificates of discharge and vacating conviction records.
- The Advocacy group Civil Survival has created a Statewide Resource Guide.
- The Department of Children, Youth & Families has more information regarding removing barriers for individuals with a founded finding of child abuse or neglect with a Certificate of Parental Improvement.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Developmental Disabilities Administration
PO Box 45310, Olympia, WA 98504-5310

June 18, 2021

Dear Tribal Leader,

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

Washington state's initial spending plan outlines targeted investments our Legislature has already appropriated that will enhance and expand its HCBS services and programs for our most vulnerable residents while also ensuring compliance with federal regulations.

As the state's Medicaid authority, the Health Care Authority submitted the attached spending plan to meet the CMS deadline of June 11. CMS will determine whether a state's activities meet requirements of 9817 of ARPA and they have committed to review and approve the spending plan reports within 30 days of submission. HCA is required to submit quarterly updates to this spending plan beginning Oct. 1, 2021. As those are submitted, we will send them to the tribes to keep you apprised of these investments.

Washington state is deeply committed to our government-to-government relationships, which seek consultation and participation by tribal governments at all stages of program and policy development. We appreciate all of the feedback you have provided to us and to the Governor's Office and the Office of Financial Management regarding the use of these enhanced funds.

Thank you for your continued work and advocacy on behalf of our state's most vulnerable residents.

Sincerely,

Debbie Roberts, Assistant Secretary

Cc: Tim Collins, Senior Director, Office of Indian Policy
Justin Chan, Equity, Diversity and Inclusion Administrator and Tribal Liaison, DDA

Washington State Health Care Authority

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

June 2021

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

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

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.

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 the elderly and disabled, individuals experiencing homelessness, and people with behavioral health needs.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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).

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.

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 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.

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.

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.

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.

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.

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.

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**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD# 21-003
RE: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency

May 13, 2021

Dear State Medicaid Director:

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). Section 9817 of the ARP provides qualifying 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). States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.

The purpose of this letter is to provide guidance to states on the implementation of section 9817 of the ARP, as well as to describe opportunities for states to strengthen the HCBS system in response to the COVID-19 Public Health Emergency (PHE), increase access to HCBS for Medicaid beneficiaries, adequately protect the HCBS workforce, safeguard financial stability for HCBS providers, and accelerate long-term services and supports (LTSS) reform under section 9817 of the ARP. This increased federal funding can help states increase community living options for people with disabilities, in accordance with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131–12134, as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999), which requires public entities to administer services to individuals with disabilities in the most integrated setting appropriate to their needs. In addition, this letter updates Medicaid retainer payment policy for HCBS providers during the COVID-19 PHE.

Section 1: Increased Federal Medical Assistance Percentage (FMAP) under Section 9817 of the ARP

Section 9817 of the ARP temporarily increases the FMAP by 10 percentage points for certain Medicaid[1] HCBS expenditures beginning April 1, 2021, and ending March 31, 2022 (see **Appendix A**). To receive the increased FMAP, states and territories must meet certain

[1] The increased FMAP under section 9817 of the ARP is not applicable to HCBS expenditures under the Children's Health Insurance Program.

requirements, referred to as "Program Requirements" below. It is important to note that the increased FMAP for HCBS for any state or territory cannot exceed 95 percent. Additionally, any payment made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures on medical assistance subject to the FMAP increase must not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108 of the Social Security Act (the Act).

A. Eligible Services

As required by section 9817 of the ARP, the increased FMAP is only available for expenditures for certain services provided under title XIX of the Act. **Appendix B** provides a brief description of eligible services under section 9817 of the ARP and includes the corresponding Form CMS-64 claiming line for these services. Later in this letter is a further discussion of Form CMS-64 and the increased FMAP claiming process. States can contact HCBSincreasedFMAP@cms.hhs.gov if they have questions about the services for which they can claim the increased FMAP.

A state may not claim the increased FMAP for any HCBS expenditures other than those listed in **Appendix B**. For example, Medicaid administrative claiming for HCBS activities performed by state No Wrong Door systems and state long-term care ombudsman programs are not eligible for the increased FMAP.[2] These HCBS activities are administrative in nature and are not considered HCBS services as defined under section 9817(a)(2)(B) of the ARP and as described in **Appendix B** of this letter.

B. Program Requirements

In accordance with section 9817(b) of the ARP, states must comply with two program requirements to receive the increased FMAP for HCBS expenditures: (1) federal funds attributable to the increased FMAP must be used to supplement existing state funds expended for Medicaid HCBS in effect as of April 1, 2021; and (2) states must use the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. Requirements are effective retroactively to April 1, 2021. In other words, states cannot use the state funds equivalent to the amount of federal funds made available by the increased FMAP to pay for HCBS that is available under the Medicaid program as of April 1, 2021. These state funds must be used to enhance, expand, or strengthen HCBS beyond what is available under the Medicaid program as of April 1, 2021. Additional information is provided later in this subsection related to the requirements for states that have implemented temporary changes to their HCBS programs in response to the COVID-19 PHE.

States will be permitted to use the state funds equivalent to the amount of federal funds attributable to the increased FMAP through March 31, 2024, on activities aligned with the goals of section 9817 of the ARP. This time period to expend funds attributable to the increased

[2] As indicated in Appendix D, states could consider using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to support these programs as part of their efforts to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.

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FMAP will provide states with sufficient time to design and implement short-term activities to strengthen the HCBS system in response to the COVID-19 PHE, as well as longer term strategies to enhance and expand the HCBS system and to sustain promising and effective programs and services. It also aligns with the two-year time period during which states may file claims for federal financial participation (FFP) for Medicaid expenditures. This time period will ensure that states have sufficient time to demonstrate that they fully expended the state funds equivalent to the amount of federal funds attributable to the increased FMAP for claims paid through March 31, 2022.

CMS expects states to demonstrate compliance with section 9817 of the ARP, beginning April 1, 2021, and until the state funds equivalent to the amount of federal funds attributable to the increased FMAP are fully expended. To demonstrate compliance with the requirement not to supplant existing state funds expended for Medicaid HCBS, states must:

- Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

Please note that these requirements do not supersede other statutory or regulatory requirements that apply to section 1915(c) waivers, or other requirements under other provisions authorizing HCBS, including requirements set forth in Special Terms and Conditions under section 1115 demonstrations and managed care authorities under which states are delivering HCBS. For example, if states have implemented temporary changes to HCBS eligibility, covered services, and/or payment rates through the Appendix K template for section 1915(c) waivers, a disaster relief state plan amendment for section 1915(i) or (k) programs, or an Attachment K for HCBS services under a section 1115 demonstration, states are expected to retain those changes for as long as allowable under those authorities (e.g., according to the end date approved under an Appendix K but no later than 6 months post PHE). However, CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP once the authority for those temporary changes has expired or if the state needs to implement changes to comply with other federal statutory or regulatory requirements.

States should contact CMS about anticipated eligibility or other changes to their HCBS programs that could take effect before the state funds equivalent to the federal funds attributable to the increased FMAP are fully expended to ensure that the changes will not result in non-compliance with these requirements.

To demonstrate compliance with the requirement to use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program, states must spend the state funds on HCBS-related services and infrastructure, as discussed further in this letter. States may use these funds to pay for additional Medicaid-covered services listed in **Appendix B** and, in turn, may be eligible for the increased

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FMAP on those expenditures one additional time. However, once the state has reinvested state funds equivalent to the amount of federal funds attributable to the increased FMAP for additional Medicaid-covered services listed in **Appendix B**, the state should not claim the increased FMAP for subsequent expenditures occurring between April 1, 2021, and March 31, 2022, on Medicaid-covered HCBS. Please see Appendix E for an example of how a state could reinvest the funds attributable to the increased FMAP in additional Medicaid-covered HCBS to receive additional federal match.

CMS understands that states may experience enrollment and utilization fluctuations unrelated to changes in state policies and procedures, especially during the COVID-19 PHE. CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP if states experience reductions in HCBS enrollment, service utilization, or expenditures that are unrelated to changes in state policies or procedures.

C. Activities to Enhance, Expand, or Strengthen HCBS

Under section 9817 of the ARP, states can implement a variety of activities, including enhancements to HCBS services, eligibility, infrastructure, and reimbursement methodologies, to enhance, expand, or strengthen Medicaid HCBS. CMS understands that some states may have an immediate need to address the continued impact of the COVID-19 pandemic while also furthering longstanding state priorities to build HCBS capacity and to pursue innovative rebalancing strategies to reform LTSS systems. The funds attributable to the increased FMAP described in section 9817 of the ARP are available to assist states to engage in simultaneous short-term and longer-term implementation activities.

Examples of activities that states can initiate as part of this opportunity are provided in **Appendices C** and **D**. These appendices include activities to address COVID-related concerns, to promote HCBS capacity building and infrastructure development activities, and to pursue innovative LTSS rebalancing strategies. CMS recognizes that states are in a unique position to identify and tailor activities that align with state goals and priorities, and accordingly, these examples are not exhaustive. CMS will determine whether a state's activities meet the requirements of section 9817 of the ARP through the required reporting discussed under *Required Reporting on Activities to Enhance, Expand, or Strengthen HCBS under the Medicaid Program*.

States should follow the applicable rules and processes for section 1915(c) waivers, other Medicaid HCBS authorities, including section 1115 demonstrations, and other managed care authorities (as applicable), if they are making changes to an HCBS program and intend to use state funds equivalent to the funds attributable to the increased FMAP to pay the state share of the costs associated with those changes. If states make programmatic changes to comply with section 9817 of the ARP, states should monitor section 1915(b) waiver expenditures. For example, states should evaluate if activities to demonstrate compliance with section 9817 of the ARP (e.g., expanding the amount, duration, or scope of existing HCBS services provided in a managed care delivery system or increasing the HCBS provider payment rates) will increase expenditures above the projections approved in a section 1915(b) waiver. If states have concerns about exceeding cost effectiveness projections, states should consider a waiver amendment, as

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appropriate, to revise cost effectiveness projections prospectively. CMS notes that increasing FMAP for HCBS services rendered through a section 1915(c) waiver generally will not have any adverse effect on demonstrating cost neutrality under a section 1915(c) waiver, but when states add HCBS to a section 1915(c) waiver, they must calculate the impact on cost neutrality prior to submitting the amendment. Section 1115 demonstrations must be budget neutral, which means that the proposed demonstration cannot cost the federal government more than it would absent the demonstration. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary.

We note that states are not limited to using state funds equivalent to the amount of the increased FMAP for services that are otherwise covered in Medicaid; however, FFP is only available for covered services. Please also note that, regardless of whether a state intends to claim FFP, the state should follow the reporting requirements described below under *Required Reporting on Activities to Enhance, Expand, or Strengthen HCBS under the Medicaid Program* for approval of the activity under section 9817 of the ARP.

States are encouraged to review guidance and information from CMS to learn more about activities to enhance, expand, and strengthen HCBS under the Medicaid program. Recently released CMS documents include a Long-term Services and Supports Rebalancing Toolkit, a State Health Officials letter regarding Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), and the Medicaid Long Term Services and Supports Annual Expenditures Report for Federal Fiscal Years 2017 and 2018.

CMS recognizes the importance of effective stakeholder engagement processes that can provide states with varied perspectives on how to expand, enhance, and strengthen HCBS. States may want to consider engaging a broad community of stakeholders—Medicaid and other state agency leadership, participants in HCBS programs, residents in long-term care facilities, HCBS providers, family members and other caregivers, the aging and disability network, health plans, and the direct support workforce—to provide insight, ideas, and feedback to inform the state's approach to developing and implementing activities under section 9817 of the ARP. Further, CMS expects that states will offer, in good faith and in a prudent manner, a public notice process, including tribal consultation as applicable, when implementing changes to their HCBS programs.

D. Required Reporting on Activities to Enhance, Expand, or Strengthen HCBS under the Medicaid Program

CMS requires participating states to submit both an initial and quarterly HCBS spending plan and narrative to CMS on the activities that the state has implemented and/or intends to implement to enhance, expand, or strengthen HCBS under the Medicaid program to demonstrate that the state is supplementing, but not supplanting, existing state funds expended for Medicaid

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HCBS.[3,4] Spending plans and narratives may be submitted in a state preferred format. The state must submit the initial HCBS spending plan and narrative within 30 days of the release of this guidance. Please submit all HCBS spending plans and narratives to HCBSincreasedFMAP@cms.hhs.gov. CMS will review and approve the initial state spending plan and narrative within 30 days of a state's submission if the submission adheres to the terms of this SMDL. CMS will provide an electronic approval notification.

- **Initial HCBS Spending Plan Projection**: The initial HCBS spending plan projection should estimate the total amount of funds attributable to the increase in FMAP that the state anticipates claiming between April 1, 2021, and March 31, 2022, as well as the anticipated expenditures for the activities the state intends to implement to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2024. The spending plan projection is the primary place for quantitative information.
- **Initial HCBS Spending Narrative**: The initial HCBS spending narrative is intended to provide information on the state's required ARP section 9817 activities and the connection between the spending plan projection and the scope of the activities. States must provide sufficient detail to demonstrate that the state's activities enhance, expand, or strengthen HCBS under the state Medicaid program. States should explain how they intend to sustain such activities beyond March 31, 2024.

When submitting the initial HCBS spending plan projection and narrative, the state should also submit a letter signed by the State Medicaid Director that provides a designated state point of contact for the quarterly spending plan and narrative submissions and an assurance of the following:

- The state is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;
- The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021.

[3] The spending plan process described here is different from the budget submission process that states complete quarterly by submitting a form CMS-37 in the Medicaid Budget Expenditure System (MBES) related to quarterly Medicaid grants awards. For the latter process, CMS will send to states instructions regarding how to account for the increase to states' projected federal share expenditures related to the increased HCBS FMAP on future budget submissions.

[4] These requirements do not necessitate that CMS promulgate new regulations because they can be implemented under existing authorities applicable to state reporting requirements set forth in section 1902(a)(6) of the Act and regulations at 42 C.F.R. § 431.16.

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States also must submit a quarterly HCBS spending plan and narrative for CMS review and approval. States may update their initial spending plan submissions through the quarterly spending plan submissions. Updates and/or modifications to the quarterly HCBS spending plan and narrative should be highlighted for ease of CMS review. The reporting interval is based on federal fiscal year quarterly reports. States must report on a quarterly basis until funds are expended. As part of the reporting cycle, two documents to be submitted:

- **Quarterly HCBS Spending Plan:** The quarterly HCBS spending plan should estimate, by quarter and in total, the amount of funds attributable to the increase in FMAP that the state has claimed and/or anticipates claiming between April 1, 2021, and March 31, 2022, as well as anticipated and/or actual expenditures for the state's activities to implement, to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2024. States must submit the quarterly projected spending plan 75 days prior to the beginning of each federal fiscal quarter beginning with the quarter that starts on October 1, 2021, and until the state's funds in an amount equivalent to the enhanced FMAP received by the state have been expended.

- **Quarterly HCBS Spending Narrative:** Similar to the narrative that was submitted with the initial HCBS spending plan, a shorter narrative for progress reports serves to provide activity updates. A state may also choose to provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS. States should explain how they intend to sustain such activities beyond March 31, 2024. States must submit the HCBS spending narrative 75 days prior to the beginning of each federal fiscal quarter beginning with the quarter that starts on October 1, 2021, and until the state's funds in an amount equivalent to the enhanced FMAP received by the state has been expended.

CMS will publicly post summary information reported by states on their initial and quarterly spending plans and narrative, including the amount of funds attributable to the FMAP increase that the state anticipates claiming or has claimed and the activities the state intends to implement and has implemented to enhance, expand, or strengthen HCBS under the state Medicaid program.

The initial and quarterly spending plans and narrative should be inclusive of any additional federal funds attributable to increased FMAP that the state expects to receive by reinvesting the state funds equivalent to the amount of federal funds attributable to the increased FMAP as state share for additional Medicaid-covered HCBS between April 1, 2021, and March 31, 2022. As noted previously, states may reinvest state funds equivalent to the amount of federal funds attributable to the increased FMAP for additional Medicaid-covered services listed in **Appendix B** once, and states should not claim the increased FMAP for subsequent expenditures occurring between April 1, 2021, and March 31, 2022 on Medicaid-covered HCBS. In the initial and quarterly spending plans and narratives, states should demonstrate that the subsequent expenditures are for activities for which the state does not receive the increased FMAP.

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When submitting the quarterly HCBS spending plan and narrative, the designated state point of contact should attest to the following via email:

- The state is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;
- The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021.

These reporting requirements are based largely on those of the Balancing Incentive Program,[5] which also provided a temporary FMAP increase for Medicaid HCBS. CMS has purposefully developed simplified reporting processes for section 9817 of the ARP to expedite the release of funds and to minimize state administrative burdens. CMS has also aligned time-frames for reporting with state FMAP claiming periods. These operational requirements, combined with using the Form CMS-64 for states to claim the increased FMAP for HCBS expenditures, provide a pathway for states to quickly access funding to implement activities to expand, enhance, and strengthen state HCBS systems. By providing quicker access to the funding, states are in a stronger position to address the impact of the COVID-19 pandemic on Medicaid HCBS beneficiaries and the providers who serve them.

Please note that these initial and quarterly HCBS spending plan and narrative requirements do not supersede any authorization requirements that apply to section 1915(c) waivers, other Medicaid HCBS authorities, including section 1115 demonstrations, and managed care authorities. States should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) or another Medicaid authority and intend to use the funds attributable to the increased FMAP to pay the state share of the costs associated with those changes. For example, if a state seeks to expand HCBS services, the state will need to explore whether an amendment to an HCBS authority is needed. Additionally, if the HCBS services will be provided in a managed care delivery system, a Medicaid managed care authority is needed to authorize those approved service(s), and changes to the state's contracts with its managed care plans to operationalize any programmatic changes may be needed. States and their actuaries will also need to determine if the actuarially sound capitation rates need to be revised and if a corresponding rate amendment is necessary (i.e., to address any expansion of these services or the amount, duration, or scope of these services or increasing the HCBS provider payments). Additionally, states that seek to contractually require their managed care plans to increase HCBS provider payments must adhere to federal

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[5] The Balancing Incentive Program (BIP), authorized by the Affordable Care Act, offered states temporary enhanced FFP for Medicaid HCBS. For an evaluation of the program see: https://aspe.hhs.gov/basic-report/final-outcome-evaluation-balancing-incentive-program.

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requirements for state directed payments in accordance with 42 C.F.R. § 438.6(c), including prior approval as required.

States should reach out to their CMS contact if they have any questions about how to request approval under Medicaid authorities. In order to facilitate the review process, it is highly recommended that states submit amendments solely focused on the activity required to meet the needs in the CMS approved initial and/or quarterly HCBS spending plan and narrative. Depending on the nature of proposed actions, and the timeframes for their implementation, Disaster Relief state plan amendments, Appendix K updates, or an Attachment K for HCBS services under a section 1115 demonstration, may be submitted, and/or traditional state plan amendments, waiver amendments, or section 1115 demonstration amendments. To the extent feasible, CMS will prioritize review and approval of these requests.

E. Claiming FFP at the Increased FMAP on the Form CMS-37 and Form CMS-64

FFP associated with the increased FMAP is available for qualifying expenditures for the HCBS services listed in **Appendix B** on a quarterly basis through Form CMS-37 and Form CMS-64 submissions in the automated Medicaid Budget and Expenditure System (MBES). The increased FMAP is available for qualifying HCBS expenditures incurred on or after April 1, 2021, through March 31, 2022.[6] Failure to follow the required steps could result in CMS initiating action to defer or disallow certain expenditures.

- **Obtaining FFP associated with the increased FMAP through the Form CMS-37:** Once the state completes the initial HCBS spending plan and narrative and, in subsequent quarters, the quarterly HCBS spending plan and narrative described in section D of this letter, CMS will provide FFP associated with the increased FMAP to states through the process described in 42 CFR § 430.30(b) for state quarterly budget estimates submitted through the Form CMS-37.

- **Obtaining FFP associated with the increased FMAP through the Form CMS-64:** Once the state completes the initial HCBS spending plan and narrative and, in subsequent quarters, the quarterly HCBS spending plan and narrative described in section D of this letter, CMS will provide FFP associated with the increased FMAP to states through the process described in 42 CFR § 430.30(c) for allowable state quarterly expenditures submitted through the CMS-64. By claiming FFP at the increased FMAP, the state agrees to use an equivalent amount of state funds, attributable to the increase from section 9817 of the ARP, only for purposes of providing new or expanded offerings of HCBS and related supports and infrastructure described but not limited to **Appendices C** and **D**. Funding must be used to supplement not supplant existing services.

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[6] The claiming process is available to states to participate in from April 1, 2021 through March 31, 2022. States that are approved to use their initial reinvestment funds for Medicaid-covered services listed in **Appendix B** may be eligible for the increased FMAP on those initial expenditures. However, once states have reinvested state funds equivalent to the amount of federal funds attributable to the increased FMAP in additional Medicaid-covered HCBS, states should not claim the increased FMAP for subsequent expenditures between April 1, 2021 and March 31, 2022 on Medicaid-covered HCBS.

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- **MBES Modifications:** We are working to modify MBES/CBES as soon as possible to reflect each state's increased FMAP.[7] Once MBES/CBES is reprogrammed to utilize the increased FMAP, the system will enable state entry of expenditures at the increased FMAP, and apply such FMAP for the actual claimed expenditures that are incurred. Expenditure reporting associated with the increased FMAP for the third quarter of fiscal year (FY) 2021 may be delayed. In those cases, states may need to report expenditures associated with the increased FMAP through prior period adjustments in subsequent quarters of the FY.

- **Other Expenditure Reporting Information:** States should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter (see **Appendix A**). The applicable FMAP is based on date of payment, not date of service for current quarter original expenditures. The FMAP applicable to expenditures for prior period adjustments should be the FMAP at which the original expenditure was claimed, for both private and governmental providers. All states are responsible for reporting Medicaid collections and overpayments on the CMS-64. States must report overpayments and collections at the same match rate at which the expenditures were originally claimed, including when the original rate incorporated the 10 percentage point FMAP increase. Recoveries of FFP must be returned at the same match rate at which they were originally claimed. Therefore, if a Medicaid expenditure was claimed using the increased FMAP, the federal share of any recoveries associated with that expenditure would have to be returned using the same increased FMAP. Consistent with existing requirements, states must document expenditures to ensure a clear audit trail, including by isolating expenditures that are matched at increased FFP rates. CMS will conduct oversight to ensure that the state expenditures are allowable and accurate, including with respect to the matching rate claimed.

- **Claiming the Increased FMAP for Managed Care Expenditures:** States should report expenditures eligible for the 10 percentage point increase on the Form CMS-64. The portion of the capitation rate that is attributable to only services in **Appendix B** and upon which an increased match may be claimed should be determined with the data utilized to develop the applicable capitation rates. The use of this claiming methodology is solely for FFP claiming purposes and does not negate the requirements that Medicaid capitation rates be actuarially sound and must be developed in compliance with federal requirements under 42 C.F.R. part 438. States have used similar claiming methodologies for FFP for services and populations such as family planning, section 1915(k) benefits, and the new adult group. States may be required to submit their managed care claiming methodologies for the increased FMAP under ARP section 9817 to CMS for review and approval.

[7] Some FFP related to ARP may be issued as separate grant awards. As such, CMS may also update the Form CMS-37 for the applicable quarters to identify budget estimates associated with the increased FMAP.

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Section 2: Medicaid Coverage of HCBS Retainer Payments during the COVID-19 PHE

Retainer payments allow certain providers to continue to bill for individuals who are enrolled in an HCBS program or who otherwise receive personal care services authorized under sections 1915(c), 1915(i), 1915(k), or 1115, as specified in their person-centered service plan, when circumstances prevent the individual from receiving the service. Previously, CMS had indicated that states may authorize up to three 30-day episodes of retainer payments for an individual during the period of the COVID-19 PHE using the Appendix K template for section 1915(c) waivers, a disaster relief state plan amendment for section 1915(i) or (k) programs, or an Attachment K for HCBS services under a section 1115 demonstration. Due to the duration of the COVID-19 PHE, which has spanned two calendar years, CMS is authorizing states to choose to offer up to three additional 30-day periods in calendar year 2021. CMS notes that these additional episodes may assist states and providers in reopening services while limiting access to buildings to allow for proper social distancing.

These additional days of retainer payments may be retroactively effective to January 1, 2021. States are encouraged to submit an Appendix K, section 1115 demonstration Attachment K, a disaster relief state plan amendment, or section 1115 demonstration amendment to implement any additional days of retainer payments. Guardrails contained in the retainer payment guidance reflected in Frequently Asked Questions issued on June 30, 2020,[8] continue to apply to retainer payments authorized in 2021; this additional flexibility is additive to that guidance.

For states that are seeking to contractually require managed care plans to make retainer payments to providers where the authorized service is covered under the managed care plan contracts, states must seek approval under 42 C.F.R. § 438.6(c) for state directed payments. In order for states to seek approval under 42 C.F.R. § 438.6(c), the retainer payments must be authorized as part of the section 1915(c) HCBS waiver, section 1115(a) demonstration for section 1915(c) HCBS services, or other Medicaid authority. Once the retainer payments are authorized under one of these authorities, a state directed payment preprint must also be submitted to effectuate the state directed retainer payments under a state's contract(s) with its managed care plans. For technical assistance on state directed payments, please contact us at statedirectedpayment@cms.hhs.gov.

Closing

CMS remains committed to supporting states with strengthening and enhancing their HCBS systems and helping to ensure that Medicaid beneficiaries receive high quality, cost-effective, person-centered services in the setting of their choice. Section 9817 of the ARP provides states with additional federal funding for Medicaid HCBS that states can use to enhance, expand, or strengthen HCBS in response to the COVID-19 PHE, accelerate LTSS reform, and address other state-specific HCBS needs and priorities, such as *Olmstead* planning. As detailed below, CMS is available to provide continued technical assistance to states when implementing this provision.

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[8] COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

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Programmatic and financial questions and state HCBS spending plans and narratives for section 9817 of the ARP can be submitted to HCBSincreasedFMAP@cms.hhs.gov.

For specific information about using section 1115(a) demonstration authority to support state efforts related to section 9817 of the ARP, contact Teresa DeCaro, Acting Group Director, State Demonstrations Group, at Teresa.DeCaro@cms.hhs.gov.

For questions about retainer payments during the COVID-19 PHE, contact Ralph Lollar at Ralph.Lollar@cms.hhs.gov.

Sincerely,

Anne Marie Costello
Acting Deputy Administrator and Director

Enclosure

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Appendix A: Applicability of the Increased Federal Medical Assistance Percentage (FMAP) to Other FMAPs Specified in the Social Security Act

Section 9817 of the ARP temporarily increases the FMAP by 10 percentage points, up to 95 percent, for allowable medical assistance expenditures for certain HCBS expenditures under the Medicaid program beginning April 1, 2021, and ending March 31, 2022. In general, the increased FMAP is available for allowable Medicaid HCBS medical assistance expenditures for which federal matching is paid ordinarily at the state-specific FMAP rate defined in the first sentence of section 1905(b) or 1905(ff) of the Act. In no case may the FMAP determined for a state be more than 95 percent with respect to such HCBS expenditures.

To the extent applicable, the increased FMAP under section 9817 of the ARP is additive to:
- Section 6008(a) of the Families First Coronavirus Response Act;
- Adult group expenditures matched at the "newly eligible" FMAP specified in section 1905(y) of the Act;
- Adult group expenditures matched at the "expansion state" FMAP specified in section 1905(z) of the Act;
- Expenditures matched at the "disaster-recovery" FMAP specified in section 1905(aa) of the Act;
- Expenditures subject to the temporary increase in FMAP specified in section 1905(ii) of the Act for medical assistance under state Medicaid plans that begin to expend amounts for all individuals described in 1902(a)(10)(A)(i)(VIII); and
- HCBS expenditures matched at the increased FMAP specified in section 1915(k) of the Act.

The increase does not apply with respect to the following Medicaid expenditures:
- Medicaid administrative expenditures, for which the matching rate is not defined in section 1905(b) or 1905(ff);
- Expenditures for family planning services eligible for 90 percent match as specified in section 1903(a)(5);
- Expenditures for services "received through" an Indian Health Service (IHS) facility (including an IHS facility operated by an Indian tribe or tribal organization), as the 100 percent match rate for these services is not the same as the state-specific FMAP defined in the first sentence of section 1905(b) to which the 6.2 percentage point FMAP increase applies;
- Expenditures matched at 100 percent for individuals in Qualifying Individuals programs;
- Health home services under section 1945 of the Act; and
- Any other expenditures not matched at the FMAP determined for each state that is defined in the first sentence of section 1905(b) or 1905(ff).

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Appendix B: Home and Community-Based Services Eligible for the ARP Section 9817 Temporary Increased FMAP

HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
State Plan Benefits		
Home Health Care	Home health services are mandatory services authorized at section 1905(a)(7) of the Act, and defined in regulations at 42 C.F.R. § 440.70. Home health services include nursing services, home health aide services, medical supplies, equipment, and appliances, and may include therapy services (physical therapy, occupational therapy, speech pathology and audiology).	Line 12-Home Health Services
Personal Care Services	Personal care services (PCS) are optional services authorized at section 1905(a)(24) and defined in regulations at 42 C.F.R. § 440.167. Personal care services can include a range of human assistance provided to persons who need assistance with daily activities. These services are provided to individuals who are not an inpatient or resident of a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), or institution for mental diseases (IMD), and may be provided in the individual's home and, at state option, in other locations.	Line 23A-Personal Care Services-Regular Payment
Self-Directed Personal Care Services	Section 1915(j) of the Act allows self-direction of state plan personal care services. Requirements are set forth in 42 CFR Part 441 Subpart J.	Line 23B-Personal Care Services-SDS 1915(j)
Case Management	Case management services, 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.	Line 24A-Targeted Case Management Services-Community Case Management Line 24B-Case Management State Wide

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HCBS Medicaid Authority	**Benefit Description**	**Corresponding Form 64 Claiming Line**
School Based Services	These services include medical assistance for covered services under section 1905(a) that are furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan. Only school based services that meet the definition of one or more of the services listed in this appendix can be claimed at the increased FMAP under section 9817 of the ARP.	[This line is under development; further instructions will be issued.]
Rehabilitative Services	The rehabilitative services benefit is 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." All rehabilitative services, including mental health and substance use disorder services, authorized under this benefit can be claimed at the increased FMAP under section 9817 of the ARP.	[This line is under development; further instructions will be issued.]

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HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
Private Duty Nursing[9]	Private duty nursing is an optional Medicaid state plan benefit authorized at section 1905(a)(8) of the Act and codified in regulation at 42 CFR § 440.80 as “nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided: (a) by a registered nurse or a licensed practical nurse; (b) under the direction of the recipient's physician; and (c) to a recipient in one or more of the following locations at the option of the State: **(1) his or her own home;** (2) a hospital; or (3) a skilled nursing facility.” The increased FMAP under section 9817 of the ARP is only applicable when the service is provided in a beneficiary’s **own home**, and is being included here based on the authority at ARP section 9817(a)(2)(B)(vii) given to the Secretary to specify additional services eligible for enhanced funding.	[This line is under development; further instructions will be issued.]
Alternative Benefit Plans (Section 1937 of the Act)	Any of the Medicaid-covered services described under section 9817 of the ARP are eligible for the enhanced match when authorized under an approved Alternative Benefit Plan.	Follow CMS-64.9 Base Category of Service Definitions
HCBS Authorities		
Section 1915(c)	Waiver authority found at section 1915(c) of the Act gives states the option to offer long-term services and supports (LTSS) in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act. For example, services may include home accessibility modifications (e.g., installing a wheelchair ramp or grab bars in a shower) to improve individuals’ ability to remain in their homes and prevent institutional admission.	Line 19A – Home and Community-Based Services – Regular Payment (Waiver)

[9] ARP section 9817(a)(2)(B) identifies certain services that are eligible for the HCBS increased FMAP. While private duty nursing is not explicitly identified as among the eligible services, CMS has determined that expenditures for private duty nursing services delivered in the home qualify under “such other services specified by the Secretary of Health and Human Services” in ARP section 9817(a)(2)(B)(vii) and are eligible for the HCBS increased FMAP.

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HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
Section 1915(i)	Section 1915(i) is an optional state plan benefit that allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target group criteria) as set forth in 42 CFR Part 441 Subpart M. States have broad latitude to determine the services to offer under the section 1915(i) state plan benefit option, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act.	Line 19B- Home and Community-Based Services - State Plan 1915(i) Only Payment
Section 1915(j) – Self-directed 1915(c) services.	Section 1915(j) of the Act allows self-direction of HCBS otherwise available under a section 1915(c) waiver program that are provided to an individual who has been determined eligible for the self-directed option. Requirements are set forth in 42 CFR Part 441 Subpart J.	Line 19C- Home and Community-Based Services - State Plan 1915(j) Only Payment
Section 1915(k)	The section 1915(k) Community First Choice (CFC) state plan benefit provides certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. States receive an extra six percentage points of federal match for CFC service expenditures. To the extent applicable, the increased FMAP under section 9817 of the ARP is additive to the increased FMAP specified in section 1915(k).	Line 19D- Home and Community Based Services State Plan 1915(k) Community First Choice
Program of All-Inclusive Care for the Elderly (PACE)	PACE provides comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. An interdisciplinary team of health professionals provides PACE participants with coordinated care.	Line 22- Programs Of All-Inclusive Care Elderly

HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
Managed Long-Term Services and Supports	Managed long term services and supports (MLTSS) refers to the delivery of LTSS through capitated Medicaid managed care programs. Only the state plan and HCBS services defined in this appendix that are provided through a managed care delivery system are eligible for the enhanced FMAP referenced in this guidance. States can implement MLTSS using an array of managed care authorities, including a section 1915(a) voluntary program, a section 1932(a) state plan amendment, a section 1915(b) waiver, or a section 1115 demonstration. Any of those managed care authorities can be "paired" with other Medicaid authorities, such as section 1905(a), 1915(i), 1915(j), or 1915(k) or an HCBS waiver program under section 1915(c) to authorize HCBS benefits to be delivered through a managed care delivery system. See *Claiming the Increased FMAP for Managed Care Expenditures* in section 1.E of this letter for more information.	[This line is under development; further instructions will be issued.]
Demonstrations		
Section 1115	States can utilize section 1115(a) demonstration authority to test new strategies to promote the objectives of the Medicaid program that are not available under other authorities. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, including but not limited to statewideness and comparability, to the extent and for the period necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide FFP for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary. Any of the Medicaid-covered HCBS services described above are eligible for the enhanced match when authorized under an approved 1115 demonstration.	Follow CMS-64.9 Base Category of Service Definitions

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Appendix C: Examples of Section 9817 of the ARP Activities to Support State COVID-Related HCBS Needs

Under section 9817 of the ARP, states can implement a variety of activities to enhance, expand, or strengthen Medicaid HCBS. This appendix provides examples of activities that states can initiate as part of this opportunity to address COVID-related concerns during the period of the public health emergency.

Activity	Activity Description
Increased Access to HCBS	
New and/or Additional HCBS	Provide new or additional Medicaid HCBS services or increase the amount, duration, or scope of HCBS to reduce the risk of institutionalization during the COVID-19 PHE.
HCBS Provider Payment Rate and Benefit Enhancements	
Payment Rates	Increase rates for home health agencies, PACE organizations, and agencies or beneficiaries that employ direct support professionals (including independent providers in a self-directed or consumer-directed model) to provide HCBS under the state Medicaid program. CMS expects that the agency, organization, beneficiary, or other individuals that receive payment under such an increased rate will increase the compensation it pays its home health workers or direct support professionals. An increase to the PACE Medicaid capitation rate can be implemented as part of the state's regular annual rate update or on a temporary basis as an interim rate increase, but must comply with existing submission, review, and approval requirements. States are not permitted to provide supplemental funding to PACE organizations outside of the PACE Medicaid capitation payment due to regulatory requirements.
Leave Benefits	Provide paid sick leave, paid family leave, and paid medical leave for home health workers and direct support professionals that are not already included in the service rate/rate methodology.
Specialized Payments	Provide hazard pay, overtime pay, and shift differential pay for home health workers and direct support professionals that are not already included in the service rate/rate methodology. Provide adult day centers with funding to make physical, operational, or other changes to safely deliver services during the COVID-19 PHE.
Supplies and Equipment	
Purchase Personal Protective Equipment (PPE) and Testing Supplies	Purchase PPE and routine COVID testing for direct service workers and people receiving HCBS, to enhance access to services and to protect the health and well-being of home health workers and direct support professionals.
Work Force Support	
Workforce Recruitment	Conduct activities to recruit and retain home health workers and direct support professionals. Offer incentive payments to recruit and retain home health workers and direct support professionals.

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Activity	Activity Description
Workforce Training	Provide training for home health workers and direct support professionals that is specific to the COVID-19 PHE.
Caregiver Support	
Supports for Family Caregivers	Support family care providers of eligible individuals with needed supplies and equipment, which may include items not typically covered under the Medicaid program, such as PPE and payment as a service provider.
Support to Improve Functional Capabilities of Persons with Disabilities	
Assistive Technology and Other Supports for Persons with Disabilities	Provide assistive technologies (including internet activation costs necessary to support use of the assistive technologies), staffing, and other costs incurred during the COVID–19 PHE in order to mitigate isolation and ensure an individual's person-centered service plan continues to be fully implemented.
Transition Support	
One-Time Community Transition Costs	Facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a community-based living arrangement in a private residence where the person is directly responsible for his or her own living expenses. One-time community transition costs may include payment of necessary expenses to establish a beneficiary's basic living arrangement, such as security deposits, utility activation fees, and essential household furnishings, for example.[10]
Transition Coordination	Provide transition coordination services to eligible individuals who had to relocate to a nursing facility or institutional setting from their homes during the COVID–19 PHE, or moved into congregate non-institutional settings as a result of the COVID-19 PHE, as well as for temporary relocation of residents from various types of congregate settings to community-based settings to reduce the risk of COVID-19 infection during the COVID-19 PHE.
Mental Health and Substance Use Disorder Services	
Skill rehabilitation	Assist eligible individuals in receiving mental health services, substance use treatment and recovery services, and necessary rehabilitative services to regain skills lost during the COVID–19 PHE.
Expanding Capacity	Recruit additional behavioral health providers, implement new behavioral health services, increase pay rates for behavioral health providers, expand access to telehealth, or make other changes to address increases in overdose rates or other mental health and/or substance use disorder treatment and recovery service needs of Medicaid beneficiaries receiving HCBS during the COVID–19 PHE.

[10] See State Health Office Letter # 21-001, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), for more information on one-time community-transition costs.

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Activity	Activity Description
Outreach	
Educational Materials	Prepare information and public health and educational materials in accessible formats for individuals receiving HCBS (including formats accessible to people with low literacy or intellectual disabilities) about prevention, treatment, recovery and other aspects of COVID–19 for eligible individuals, their families, and the general community. States could leverage relationships with community partners, such as Area Agencies on Aging, Centers for Independent Living, non-profit home and community-based services providers, and other entities providing HCBS for these activities.
Language Assistance	Pay for American sign language and other language interpreters to assist in providing HCBS to eligible individuals and to inform them about COVID–19.
Access to COVID-19 Vaccines	
Support for Individuals with HCBS Needs and Their Caregivers	Assist with scheduling vaccine appointments. Provide transportation to vaccine sites. Provide direct support services for vaccine appointments. Develop and implement in-home vaccination options. Education and outreach about the COVID-19 vaccine.

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Appendix D: Examples of Section 9817 of the ARP Activities to Support State HCBS Capacity Building and LTSS Rebalancing Reform

Under section 9817 of the ARP, states can implement a variety of activities to enhance, expand, or strengthen Medicaid HCBS. This appendix provides examples of activities that states can initiate as part of this opportunity to support state HCBS capacity building and LTSS rebalancing.

Activity Function	Activity Description
New and/or Additional HCBS	Provide new or additional Medicaid HCBS services or increase the amount, duration, or scope of HCBS; funding must be used to supplement not supplant existing services.
Building No Wrong Door Systems (NWD)	Improve access to HCBS through non-administrative NWD activities such as establishing toll free phone lines, developing informational websites and automating screening and assessment tools, and conducting marketing and outreach campaigns.
Strengthening Assessment and Person-Centered Planning Practices	Adopting standardized functional assessments. Enhancing person-centered planning practices. Providing person-centered planning training.
Quality Improvement Activities	Upgrading critical incident management reporting systems. Adopting new HCBS quality measures. Implementing improvements to quality measurement, oversight, and improvement activities. Implementing the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) or another experience of care survey.
Developing Cross-System Partnerships	Creating incentives for managed care plans or providers to develop partnerships with community-based organizations, social service agencies, counties, housing agencies, and public health agencies. Promoting provider collaborations by requiring the formation of and participation in regional/local provider networks. Building Medicaid-housing partnerships. Building social determinants of health (SDOH) network partnerships.
Training and Respite	Providing caregiver training and education. Providing in-person or virtual training to beneficiaries, caregivers, and/or providers to support community integration (e.g., to support beneficiaries with seeking employment, to train providers or caregivers to support individuals with behavioral challenges that can make it difficult to access community resources). Providing respite services to support family caregivers.
Eligibility Systems	Implementing new eligibility policies and/or procedures, such as to implement expedited eligibility for HCBS (subject to CMS approval), or streamline application and enrollment processes
Reducing or Eliminating HCBS Waiting Lists	Increasing the number of HCBS waiver slots in order to reduce or eliminate waiver waiting lists.

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Activity Function	Activity Description
Institutional Diversion	Embedding options counselors into hospital discharge programs. Strengthening/improving Preadmission Screening and Resident Review (PASRR) processes to prevent unnecessary institutionalization.
Community Transition	Expanding a community transition program to additional populations or institutional settings. Improving the use and availability of data (e.g., Minimum Data Set, Medicare and Medicaid claims and encounter data) to support community transition programs. Providing additional one-time community transition services or other HCBS that can help to support the transition from institutional settings.
Expanding Provider Capacity	Expanding self-directed programs. Creating financial incentives to expand the number, retention rates, and expertise/skills of the direct care workforce. Providing nursing facilities or other institutional settings with funding to convert to assisted living facilities or to provide adult day services, respite care, or other HCBS.
Addressing Social Determinants of Health and Health Disparities	Assessing health disparities among older adults and people with disabilities. Testing alternative payment methodologies or the delivery of new services that are designed to address SDOH that may include housing-related supports such as one-time transition costs, employment supports, and community integration, among others. Providing more intensive care coordination for individuals with significant socioeconomic needs based on risk-stratification modeling.
Employing Cross-system Data Integration Efforts	Establishing data sharing and governance agreements that enumerate standards and practices for data sharing among state and county agencies, providers, and community-based organizations such as with the National Adult Maltreatment Reporting System. Providing training and technical assistance to build providers' performance measurement and predictive analytics capabilities. Building a stronger health and welfare system by integrating claims and encounter data with the state's incident management system.
Expanding Use of Technology and Telehealth	Making investments in infrastructure to facilitate incorporation of HCBS into interoperable electronic health records (EHRs). Covering individual tele-communications start-up costs (e.g., equipment, internet connectivity activation costs). Testing the impact of assistive technologies on the need for in-person supports. Providing smartphones, computers, and/or internet activation fees to address functional needs, promote independence, and/or support community integration.
Providing Access to Additional Equipment or Devices	Providing eyeglasses, wheelchair transfer boards, and adaptive cooking equipment to address functional needs, promote independence, and/or support community integration.

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Activity Function	Activity Description
Adopting Enhanced care Coordination	Implementing health information technology care coordination enhancements such as notification systems and capabilities (e.g., hospital admission, discharge, and transfer notifications) to share information across different health care settings. Integrating Medicare and Medicaid data and/or improving Medicaid managed care plan access to Medicare data to improve care coordination for individuals receiving HCBS who are dually eligible for Medicare and Medicaid. Implementing integrated care models that can more effectively address the needs of complex populations.

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Appendix E: State Example

States may use the state funds equivalent to the amount of federal funds attributable to the increased FMAP to cover additional Medicaid-covered HCBS. If a state chooses to cover additional Medicaid-covered HCBS, the state would be able to use the applicable portion of the state funds attributable to the increased FMAP as the state share and receive federal financial participation (FFP) for the additional HCBS expenditures it incurs. States that are approved to use their initial reinvestment funds for Medicaid-covered services may be eligible for the increased FMAP on those initial expenditures once, if the additional expenditures are incurred between April 1, 2021, and March 31, 2022. However, once states have reinvested state funds equivalent to the amount of federal funds attributable to the increased FMAP for additional Medicaid-covered services listed in **Appendix B**, states should not claim the increased FMAP for subsequent expenditures occurring between April 1, 2021, and March 31, 2022, on Medicaid-covered HCBS. This example shows how the state could reinvest the funds in additional Medicaid-covered HCBS to receive additional federal match.

State Example

State A has a regular FMAP rate of 70.00%. With the 6.2 percentage point Families First Coronavirus Response Act (FFCRA) increase,[11] the state has an FMAP rate of 76.2%. The 10 percentage point increase under ARP section 9817 is additive to the state's FMAP rate and results in an enhanced rate of 86.2% for qualified HCBS expenditures between April 1, 2021, and March 31, 2022 for **State A**.[12]

As shown in Table 1, **State A** expends $2.5 billion on services that qualify for the temporary 10 percentage point FMAP increase during the period April 1, 2021, through March 31, 2022, at a quarterly rate of $625 million. At this level of expenditures, the state would be eligible to receive $62.5 million in federal funds attributable to the HCBS increased FMAP each quarter, or a total of $250 million for expenditures between April 1, 2021, and March 31, 2022.

As shown in Table 2, **State A** intends to use the initial reinvestment funds for Medicaid-covered services listed in **Appendix B** and to spend an equal portion of the $250 million of state funds equivalent to the amount of federal funds attributable to the increased FMAP on an annual basis between April 1, 2021, and March 31, 2024; this is equal to $83.33 million for each of these periods: April 1, 2021-March 31, 2022, April 1, 2022-March 31, 2023, and April 1, 2023-March 31, 2024. If the state used 100% of the initial reinvestment funds for Medicaid-covered services listed in **Appendix B** in each of these periods, this would equate to an additional $603.84 million in total computable HCBS expenditures between April 1, 2021, and March 31, 2022 when the state is still eligible for the enhanced HCBS FMAP, $277.77 million in total computable HCBS

[11] Section 6008 of the FFCRA provides for a temporary 6.2 percentage point FMAP increase to each qualifying state and territory's FMAP under section 1905(b) of the Act, effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of HHS for COVID-19, including any extensions, terminates.

[12] For illustrative purposes only, this scenario assumes that the FFCRA 6.2 percentage point FMAP increase would continue to be available through March 31, 2022. If the public health emergency ends on or before December 31, 2021, the state's FMAP rate in this scenario would decrease by 6.2 percentage points beginning on the date in which the FFCRA increase is no longer available to states.

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expenditures between April 1, 2022, and March 31, 2023, and $277.77 million in total computable HCBS expenditures between April 1, 2023, and March 31, 2024.

Table 1: State Example Showing State and Federal Share and the Funds Attributable to the HCBS FMAP Increase

	Q3 FY 2021	Q4 FY 2021	Q1 FY 2022	Q2 FY 2022	Total – Q3 FY 2021-Q2 FY 2022
Total computable	$625.00 million	$625.00 million	$625.00 million	$625.00 million	**$2,500.00 million**
State share[13]	$86.25 million	$86.25 million	$86.25 million	$86.25 million	**$345.00 million**
Federal share[14]	$538.75 million	$538.75 million	$538.75 million	$538.75 million	**$2,155.00 million**
Funds attributable to the HCBS FMAP increase	$62.50 million	$62.50 million	$62.50 million	$62.50 million	**$250.00 million**

Table 2: State Example Showing Reinvestment in Additional Medicaid-Covered HCBS

	Q3 FY 2021-Q2 FY 2022	Q3 FY 2022-Q2 FY 2023	Q3 FY 2023-Q2 FY 2024	Total
Total computable[15]	$603.84 million	$277.77 million	$277.77 million	**$1,159.39 million**
State share[16]	$83.33 million	$83.33 million	$83.33 million	**$250.00 million**
Federal share[17]	$520.51 million	$194.44 million	$194.44 million	**$909.39 million**
Funds attributable to the HCBS FMAP increase	$60.38 million	$0.00 million	$0.00 million	**$60.38 million**

[13] Assumes the FFCRA increase is available through 3/31/2022. State share is equal to: 13.8% with the HCBS enhanced FMAP and the FFCRA increase.
[14] Assumes the FFCRA increase is available through 3/31/2022. Federal share is equal to: 86.2% with the HCBS enhanced FMAP and the FFCRA increase.
[15] In order to determine the total computable HCBS expenditures for which a state could claim FFP using, as state share, the state funds equivalent to the amount of federal funds attributable to the increased FMAP, divide the amount of state funds by 1 minus the state's FMAP. In this example, divide $62.5 million by .138 to calculate total computable expenditures of $603.84 million for Q3 FY 2021-Q2 FY 2022 and by .300 to calculate total computable expenditures of $277.77 million for Q3 FY 2022-Q2 FY 2023 and for Q3 FY 2023-Q2 FY 2024. This amount can then be multiplied by the state's FMAP rate for the applicable period to determine the amount of additional federal dollars the state could claim on those additional expenditures.
[16] Assumes the FFCRA increase is no longer available after 3/31/2022. State share is equal to: 13.8% with the HCBS enhanced FMAP and the FFCRA increase; and 30.0% without the HCBS enhanced FMAP and the FFCRA increase.
[17] Assumes the FFCRA increase is no longer available after 3/31/2022. Federal share is equal to: 86.2% with the HCBS enhanced FMAP and the FFCRA increase; 70.0% without the HCBS enhanced FMAP and the FFCRA increase.

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Developmental Disabilities Administration Communications Cloud

Developmental Disabilities Administration uses a communication system called **GovDelivery** that allows DDA to send:

- News and announcements;
- Provider information;
- Care Provider Bulletins;
- Resources;
- Trainings and events; and
- Job and contract openings.

Subscribers can choose **what** they want to see and in what **format** (text or email).

Subscribers can **manage preferences** to choose **topics** to receive information about:

Emergency Alerts

Employment and Contracting Opportunities

- DDA employment opportunities
- Contracting opportunities with DDA

Information

- Home and Community Based services
- Legislation
- News and announcements
- Rules and policies
- Publications, brochures
- Residential habilitation center news and Information
- Resources
- Survey opportunities and results

Projects

- Adult family home Meaningful Activities Project
- Advanced Home Care Aide Specialist
- Consumer Directed Employer

- Electronic Visit Verification

Provider Information

- Background checks
- Billing/payment information
- Care Provider Bulletins
- Dear Provider letters
- Service providers
- Provider resources

Trainings and Events

- Trainings and events

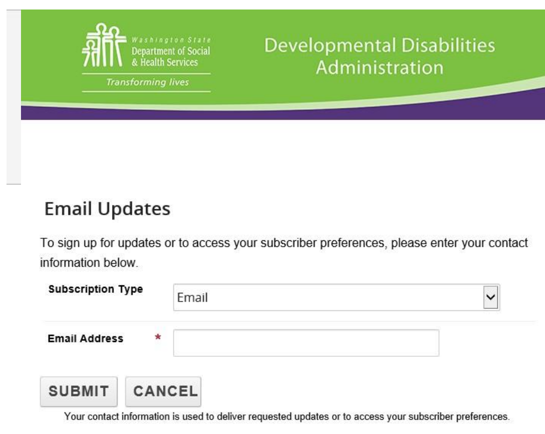
You can sign up for some topics by **Provider Type:**

- Adult family homes
- Alternative living
- Child foster care
- Child group care
- Community crisis stabilization services
- Community protection providers
- Companion homes
- Counties and county-contracted providers
- Group homes
- Group training homes
- Hospitals
- Individual providers
- Licensed staffed residential programs
- Nursing facilities
- Overnight planned respite services
- Parents
- Professional services providers
- State Operated Living Alternatives
- Supported Living
- Waiver providers

Directions to sign up for GovDelivery:

1. Click on https://public.govdelivery.com/accounts/WADSHSDDA/subscribers/new

   Or visit the DDA home page: www.dshs.wa.gov/dda/ and click on the icon below.



2. Enter your email address.

3. Choose which alerts you would like to receive.

4. Check the boxes for which counties you would like to receive alerts.

5. Check the boxes for which provider types you would like to receive information.

6. Check the boxes for other organizations that you may be interested in receiving updates from.

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Requesting DDA Services

How can a person request services?

- Call a local toll-free number (www.dshs.wa.gov/dda/service-and-information-request); or
- Request a packet of the required forms and documents by filling out a Service and Information Request (www.dshs.wa.gov/dda/service-and-information-request).

Why request services? DDA offers many different services and programs including personal care, respite, employment, residential supports, and much more. Becoming a client earlier in life will help you transition during different stages of life.

What is the Service and Information Request?
It is an online form to request information and services. The form takes less than five minutes to fill out and has few questions. Once it is filled out and submitted, it is sent to an email box in the region where the person lives. A person is designated at each region to review the requests and make referrals to the appropriate staff, depending on the services they are requesting.

Need help completing the forms and locating documentation?

- Contact your DDA Local Tribal Liaison (see next page); or
- Contact your local DDA office or the main regional office listed below:

County of Residence	Phone
Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, Yakima	(800) 462-0624
Island, King, San Juan, Skagit, Snohomish, Whatcom	(800) 788-2053
Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Pierce, Skamania, Thurston, Wahkiakum	(800) 248-0949

Washington State Department of Social & Health Services

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DSHS List of DDA Local Tribal Liaison Staff

Region 1				
Tribe	**Counties**	**DDA Local Liaison**	**Telephone**	**Email**
Colville	Ferry, Okanogan, Spokane	Kim Abe-Gunter	509.329.2948	AbeGuKi@dshs.wa.gov
Kalispel	Pend Oreille	Kim Abe-Gunter	509.329.2948	AbeGuKi@dshs.wa.gov
Spokane	Stevens	Kim Abe-Gunter	509.329.2948	AbeGuKi@dshs.wa.gov
RAIO – NATIVE Project	Spokane	Kim Abe-Gunter	509.329.2948	AbeGuKi@dshs.wa.gov
Yakama	Klickitat, Yakima	Nathan Sitton	509.225.7907	SittoNT@dshs.wa.gov

Region 2				
Tribe	**Counties**	**DDA Local Liaison**	**Telephone**	**Email**
Lummi	Whatcom	Leslie Kivett	360.714.5014	Leslie.Kivett@dshs.wa.gov
Muckleshoot	King, Pierce	John Pashek	253.372.5755	PasheJJ@dshs.wa.gov
Nooksack	Whatcom	Leslie Kivett	360.714.5014	Leslie.Kivett@dshs.wa.gov
Samish	San Juan	Leslie Kivett	360.714.5014	Leslie.Kivett@dshs.wa.gov
Sauk-Suiattle	Snohomish, Skagit	Kristen Petrakis	425.977.6520	kristen.petrakis@dshs.wa.gov
RAIO - Seattle Indian Health Board	King	John Pashek	253.372.5755	PasheJJ@dshs.wa.gov
Snoqualmie	King	John Pashek	253.372.5755	PasheJJ@dshs.wa.gov
Stillaguamish	Snohomish	Kristen Petrakis	425.977.6520	kristen.petrakis@dshs.wa.gov
Swinomish	San Juan, Skagit	Leslie Kivett	360.714.5014	Leslie.Kivett@dshs.wa.gov
Tulalip	Snohomish	Kristen Petrakis	425.977.6520	kristen.petrakis@dshs.wa.gov
Upper Skagit	Skagit	Leslie Kivett	360.714.5014	Leslie.Kivett@dshs.wa.gov

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Region 3				
Tribe	**Counties**	**DDA Local Liaison**	**Telephone**	**Email**
Chehalis	Grays Harbor, Thurston	Jerry Mullin	360.669.6659	jerry.mullin@dshs.wa.gov
Cowlitz	Cowlitz	Lucy Meyer	360.545.7037	lucy.meyer@dshs.wa.gov
Hoh	Jefferson	Tobias Clawson	360.461.4391	tobias.clawson@dshs.wa.gov
Jamestown S'Klallam	Jefferson	Tobias Clawson	360.461.4391	tobias.clawson@dshs.wa.gov
Lower Elwha	Clallam	Tobias Clawson	360.461.4391	tobias.clawson@dshs.wa.gov
Makah	Clallam	Tobias Clawson	360.461.4391	tobias.clawson@dshs.wa.gov
Nisqually	Pierce, Thurston	Cathleen Corcoran	564.999.1432	cathleen.corcoran@dshs.wa.gov
Port Gamble S'Klallam	Kitsap	Alex Boede	360.265.3403	boedeaj@dshs.wa.gov
Puyallup	Pierce	Priscilla Ogden	253.753.3245	ogdenpc@dshs.wa.gov
Quileute	Clallam	Tobias Clawson	360.461.4391	tobias.clawson@dshs.wa.gov
Quinault	Grays Harbor	Rebecca Roadman	360.998.0004	roadmra@dshs.wa.gov
Shoalwater Bay	Pacific	Greta Smith	360.214.6451	greta.mcdougall@dshs.wa.gov
Skokomish	Mason	Nick Stigall	360 463 3217	StigaRM@dshs.wa.gov
Squaxin Island	Mason	Nick Stigall	360 463 3217	StigaRM@dshs.wa.gov
Suquamish	Kitsap	Alex Boede	360.265.3403	boedeaj@dshs.wa.gov

For more information, please contact your DDA Central Office Tribal Liaison

Justin K. Chan
Office Phone: 360.407.1586
Mobile Phone: 360.764.9909
Email: ChanJK@dshs.wa.gov OR justin.chan@dshs.wa.gov

STATE OF WASHINGTON

July 6, 2021

Dear Tribal Leader:

This is a formal request to schedule a meet and greet with Behavioral Health Administration (BHA) Acting Assistant Secretary Kevin Bovekamp, Deputy Assistant Secretary Sjan Talbot and Tribal Affairs Administrator Marie Natrall-Ackles. The purpose of the meeting is to discuss BHA's services and resources and facilitate collaboration between BHA and tribes to provide efficient services to tribal members in Washington State.

If you have any questions or concerns, please contact:

Tim Collins, Senior Director, Office of Indian Policy, DSHS
Phone: 360-902-7816; Email: timothy.collins@dshs.wa.gov

Marie Natrall, Tribal Affairs Administrator, Behavioral Health Administration, DSHS
Phone: 360-790-0950; Email: natramf@dshs.wa.gov

Please forward this information to any interested party.

Sincerely,

Kevin Bovenkamp

Kevin Bovenkamp
Acting Assistant Secretary, BHA
Department of Social and Health Services

cc: Tim Collins, Senior Director, OIP, DSHS

Washington State Department of Social & Health Services
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Division of Vocational Rehabilitation
IPAC Meeting Updates
July 14, 2021

SUMMARY

The Division of Vocational Rehabilitation (DVR) helps individuals with disabilities to participate fully in their communities and become employed. We provide individualized vocational rehabilitation services and counseling to people with disabilities, as well as provide technical assistance and training to employers about the employment of people with disabilities. DVR continues its cooperative working relationships and service delivery commitments with all federally recognized tribes in Washington, including those who do not operate federally funded Tribal VR programs.

GENERAL UPDATE

DVR Tribal Liaisons have continued to meet with tribal partners in their region quarterly via Zoom. DVR continues to invite Tribal VR partners to participate in trainings, workshops, and on interview panels.

On June 1, DVR hired Cassi Villegas as our first Equity, Diversity, and Inclusion (EDI) Administrator who also serves as the Statewide Tribal Liaison. DVR's EDI goals are to become a transformational, anti-racist and equitable organization, and to actualize our Vision: "Dedicated professionals leading the field of vocational rehabilitation, delivering exceptional experiences to every customer, every time."

CURRENT ORDER OF SELECTION WAITLIST NUMBERS

Current Waitlist Numbers	2313
Current AI/AN Waitlist Numbers	158
Number Released (since Sept '19)	5569
Number of AI/AN Released	326

-DVR is releasing 400 individuals from the waitlist monthly.

STRATEGIC PLANNING

DVR's 2021-2023 Strategic Plan, effective July 1, includes the strategic objective: "Identify service delivery improvements for individuals who identify as American Indian or Alaska Native." The action plan includes: assessing need for improvements to procedures addressed in the joint memorandum of understanding with Washington's tribal VR programs for referrals, joint cases, financial responsibility, shared training opportunities, information sharing and communication; developing outreach strategies in consultation with Native American/Alaska Native organizations; and identifying training resources and experiential opportunities to develop DVR staff cultural awareness in working with individuals with disabilities with Native American or Alaska Native heritage.

BUDGET UPDATE

DVR is seeing a slow increase in expenditures and we anticipate this increase to continue as we reopen and return to the "new" normal operations. The budget for Biennium 21-23 has been enacted and we are currently working on allotments. DVR has received $5,398,644 of program income in SFY21.

PROJECTS UPDATE

The Business Management Modernization Project (BMMP) encompasses two phases of business modernization for DVR - the Case Management System (CMS) phase, which replaces our current CMS, and the Electronic Document Management System (EDMS) phase, which is all about going paperless. DVR continues transferring open cases into our new EDMS. We are finalizing the CMS project schedule and designing the new CMS solution to meet DVR's business needs. Expected rollout is July 2022.

STAFF CONTACT

Cassi Villegas, Tribal Liaison, 360-764-0731, cassi.villegas@dshs.wa.gov

ESA UPDATES HANDOUT

INDIAN POLICY ADVISORY COMMITTEE (IPAC) JULY 14, 2021

COVID-19, ESA Resources and Services

- Governor Inslee announced that effective 6/30/2021, all industry sectors previously covered by guidance in the Healthy Washington – Roadmap to Recovery or the Safe Start Reopening Plan may return to usual capacity and operations, with limited exceptions for large indoor events. Requirements for places of employment issued by the Washington State Department of Labor and Industries will be updated here. State employees will return to office buildings in coordination with agency leadership and human resources…Most DSHS staff who are currently teleworking will continue to do so through Labor Day. The Community Services Division (CSD) staff has a skeleton crew in local offices to provide limited in-person services to the public, by appointment only *(i.e. issuing EBT cards for homeless customers, issuing some support services for WorkFirst participation, and providing a few other limited services)*.

- ESA Resources, Services and Policy changes in response to COVID-19:
  - CSD Programs and Services Video (COVID-19)
  - CSD Policy Changes in response to COVID-19 and this CSD COVID-19 Response fact sheet
  - Pandemic EBT is expanded to Children under Age 6, for the full details visit our P-EBT page.
  - ESA Overview of Programs and Services Table
  - ESA Reduced Cost Services Guide (DSHS 22-1841)
  - How to find services, see if I qualify or apply for services? –Visit WashingtonConnection.org
  - Dismantle Poverty in Washington: Website, Executive Summary, 10-Year Plan, Action Toolkit, DSHS Receives Grant to Advance Equitable Economic Recovery

Community Services Division (CSD)

- Effective April 1, 2021, CSD shut down the Able-Bodied Adults Without Dependents, or ABAWD, Navigator Program. CSD was forced to end this program due to the US Department of Agriculture, USDA, Food and Nutrition Service, FNS, ending the special funding it had been providing, known as "Pledge Funding" to serve at-risk ABAWD clients. ABAWD clients who were scheduled for a Navigator appointment after April 1, 2021 were offered Basic Food Employment and Training, or BFET, services.

  CSD had requested and recently been approved for an ABAWD statewide waiver. The state has been approved for this waiver by USDA FNS effective June 1, 2021. This waiver allows for ABAWD customers to be exempt from ABAWD work requirements through May 31, 2022.

- DSHS continues to request authorization of Emergency Food Supplements for families not already receiving the maximum allotment for their household size. Effective May 1, 2021, households approved for Basic Food but receiving a zero allotment are not considered participating SNAP

households for emergency allotments purposes. This is a recent change based on guidance issued from the Food and Nutrition Service on April 21, 2021. Households receiving the Emergency Allotment receive at least $95 more than their initially approved benefit amount. These households will continue to receive the maximum allotment for their household size each month that the federal government approves.

- On July 1, 2021, new Time Limit Extension (TLE) categories will be available for participants who have exhausted 60 months on TANF/SFA. The first categories are homeless participants or those who have a child in their home who meet the broad McKinney-Vento definition of homeless described below. These new homeless categories allow families experiencing housing instability or caring for a child in this situation to receive a TLE and continued cash assistance. In addition, for participants that don't meet any other TLE category, the Post-Pandemic TLE hardship category is in effect from July 1, 2021, to June 30, 2022. This ensures all participants can continue to receive TANF during the upcoming year of recovery from the pandemic.

  Effective July 1, 2021, the payment standards for CSD cash programs, with the exception of Diversion Cash Assistance and Aged, Blind and Disabled Assistance, will increase by 15%. This change will also increase each program's income limits.

  Rule changes for WF participation requirements eff 7/1/21- Effective July 1, 2021, Substitute House Bill 2441 changes WorkFirst Non-compliance Sanction, NCS, policies. The mandatory WorkFirst participation requirements and associated sanctions are suspended due to the COVID-19 pandemic; therefore, these changes will not begin to affect families until normal rules are back in place in September 2021.

  Changes include-
    - Participants have two continuous months of non-compliance before CSD reduces their cash grant. This provides participants with multiple opportunities to reengage prior to facing financial penalties.
    - Participants have an additional ten months on a reduced grant before NCS termination. The additional time allows more opportunity for WorkFirst staff to help participants reengage before termination.

- Washington State has elected to use the one-time, lump-sum amount of $375 for Summer P-EBT. The following children will automatically receive Summer P-EBT benefits:
    - All children determined eligible for free or reduced-price school meals that were registered and enrolled at the end of the school year in a Washington school that would have normally participated in the National School Lunch Program and School Breakfast Program.
    - All children under the age of six in a household who's Basic Food begins or ends in June, July, or August 2021.

Our P-EBT Vendor, Accenture, will automatically provide the one-time, lump-sum benefit onto existing P-EBT cards in the following tentative issuance months:
  - July 2021 for children qualified for free or reduced-price school meals.

- August 2021 for children under the age of six who are eligible for Basic Food.

Kids under 6 approved- USDA's Food and Nutrition Service has approved Washington's plan to extend P-EBT benefits to Basic Food recipient children under the age of six. This expansion of P-EBT to children under six is different from P-EBT for children in school in the following ways:

Any child meeting the following criteria will qualify for P-EBT automatically:

- Under the age of six;
- A member of a household that received Basic Food for any month between October 1, 2020, to June 30, 2021, and
- Reside in a county with a school that has had limited on-site meal service.
- Families do not have to apply
- Existing information known to CSD for Basic Food eligibility will be used rather than school enrollment information.
- Benefit amounts will vary depending on the county of residence.
- Families with active food cases should ensure that DSHS has their current address on file prior to July 2021.

October 2020 through March 2021 benefits will be issued in July 2021. April 2021 through June 2021 benefits will be issued in August 2021.

Division of Child Support (DCS)

- DCS staff continue to use virtual meeting platforms (i.e. Skype, Zoom, Microsoft Teams), telephone and email to connect with program partners, community stakeholders, and other agencies

- DCS in-person outreach services to tribes are still suspended - though we are looking forward to resuming in-person activities when it's safe to do so.

- Since April 2020, DCS has adapted our policies and practices to better serve families and individuals impacted by COVID-19. We are balancing the need for continued payments to parents with enforcement actions against those with an inability to pay due to COVID-19.

  Our goals include:

  - Providing excellent customer service and closely evaluating whether enforcement actions (i.e. license suspension, bank hits, contempt) are appropriate to the circumstances

  - Following federal government guidelines on the advance payments of the Child Tax Credit (CTC) that began this month (July 2021). Under the American Rescue Plan, many parents will receive CTC payments from the US Treasury through the end of this year. These payments are NOT subject to intercept for past-due child support.
    - Note: Parents who file their 2021 tax return and claim the CTC at that time will be subject to federal regulations for child support intercept. But DCS is advising staff

to avoid intentionally withholding advance CTC payments from bank accounts, and to promptly release CTC funds attached unintentionally.

- Suspending non-cooperation notices for TANF parents who are unable to cooperate with DCS requests because of the pandemic
- While determining income/establishing a child support obligation, recognizing that COVID-19 may drastically affect earnings and the ability to work
- Promptly reviewing hardship Conference Board requests from parents who are being impacted by COVID-19

Income Determination

- In early 2020, DCS began updating guidelines around determining parents' income during the order establishment process. The intent has been to provide staff with more information about applying the statute (RCW 26.19.071) and increased flexibility when imputing income resulting in orders that better reflect the economic reality of the parent(s).

  Several DCS teams have been using and testing the new guidelines over that past 14 months, and the project was recently expanded to include additional staff and cases. The data collected is being analyzed by the ESA Management Accountability and Performance Statistics (EMAPS) team for a variety of indicators.

DCS Policy Updates

- **Abatement.** Effective February 1, 2021, Washington state child support orders must contain provisions about abatement of child support during incarceration. The new law creates a *rebuttable presumption* that parents who are incarcerated for, or sentenced to, a period exceeding 6 months do not have the ability to pay support and child support should be abated during confinement. DCS Policy continues to work through the implementation of this new requirement.
  - Support abates to $10/mo. per order. This does not actually *modify* the underlying order amount but instead temporarily reduces child support during the period of confinement and up through the end of the third month after release.
  - Following first day of the fourth month after the parent's release, the monthly support obligation is automatically raised to 50% of the amount of the ordered amount. The obligation increases again to 100% of the amount in the original order one year after release.
  - If DCS learns an NCP is incarcerated for, or sentenced to, at least six months and the underlying child support does not have abatement language, the law requires DCS to refer those orders for modification to include abatement language and a determination of

abatement.

- DCS does NOT have the authority to modify out-of-state or tribal orders to include abatement provisions. Requests to DCS to modify a "non-Washington" order will be referred back to the appropriate jurisdiction.

- A reminder that tribal employers are exempt from the Washington New Hire Reporting requirement (RCW 26.23040) but have the option to report. DCS welcomes updates from tribal contacts and partners that can assist us in identifying and coding tribal businesses in our system. Language on the ESA, Division of Child Support new hire reporting website (https://www.dshs.wa.gov/esa/division-child-support/new-hire-reporting) clarifies the reporting requirement:
  - *"DCS recognizes Indian tribal sovereignty. Indian tribes, tribally owned businesses, and Indian owned businesses located on reservations are exempt from new hire reporting requirements. However, voluntarily reporting of new or re-hired employees is appreciated."*

Bills impacting ESA Clients and supporting our Poverty Reduction Goal

SHB 1151 Bolstering economic recovery by providing public assistance to households in need (Passed; *Effective date July 25, 2021, except for section 1, which becomes effective March 31, 2021, and section 2, which becomes effective July 1, 2022*): This bill was formerly three separate ESA request legislation proposals, now combined into a single bill. Extends the emergency assistance program to households without children, pursuant to a state of emergency and order from the Governor. Allows the emergency assistance program to be used more than once in a 12 month period. Establishes a new, one-time cash benefit for households with children who exit Basic Food due to exceeding the maximum income limit or requesting closure of their benefits. The amount of the cash benefit will be determined by the amount appropriated in the budget (proposed at $10). The bill further provides 5 months of transitional food assistance for these families. Finally, the bill also directs DSHS to update standards of need for cash assistance programs by July 1, 2022.

2SSB 5214 Concerning economic assistance programs: Expands Temporary Assistance for Needy Families (TANF) time limit extension hardship criteria by adding that a person may qualify for an extension to the 60-month lifetime time limit if they received a TANF grant during a month in which the unemployment rate was equal to or greater than 7 percent. Provides that the extension is equal to the number of months that the unemployment rate was equal to or greater than 7 percent. The bill will impact families' beginning July 1, 2022, after the universal time limit extension during State Fiscal Year 2022 ends.

ESHB 1297 Concerning working families tax exemption: Updates the working families tax exemption for state sales tax. Eligibility for the working families tax exemption is based on eligibility for the federal Earned Income Tax Credit (EITC), though it includes taxpayer families filing with an individual tax identification number (ITIN) currently excluded from the earned income tax credit. The bill intends to stimulate local economic activity, advance racial equity, and promote economic stability and well-being for lower income working people, including individual tax identification number filers,

by updating and simplifying the structure of the working families tax exemption. State EITCs can amplify the effects of the federal EITC and be an effective antipoverty policy tool.

SSB 5068 Improving maternal health outcomes by extending coverage during the postpartum period: Directs the Healthcare Authority (HCA) to maintain healthcare coverage for 12 months for individuals receiving postpartum coverage on or after the expiration date of the federal public health emergency declaration related to COVID-19. This bill also directs HCA to provide 12 months of continuous healthcare coverage to individuals who are postpartum and reside in Washington State, have countable income at our below 193% of the Federal Poverty Level and are not otherwise eligible under Title XIX of the Federal Social Security Act regardless of a change in income during the period of eligibility. HCA must begin providing 12 months of post-partum coverage by June 1, 2022.

Highlights of the American Rescue Plan Act (ARPA):

The long awaited relief from H.R 1319, the federal American Rescue Plan Act (ARPA) of 2021 passed, and the State is anxious to take advantage of the time limited funding available under the act. Below are some of the highlights, as well as parameters, of those funds.

- **TANF Pandemic Emergency Assistance funding**
    - May use up to 15% of funds towards administrative expenses
    - Must be expended by the end of federal fiscal year 2022
    - Must be spent on non-recurrent short term benefits
    - Must not supplement or supplant existing state and federal spending on TANF related services or activities

- **Supplemental Nutrition Assistance Program (SNAP) funding**
    - **SNAP Benefit Increase** – Extends 15% SNAP benefit increase from June 2021 to September 2021.

    - **SNAP Administration Relief** -Provides administrative funding relief to states for the increase in SNAP participation.

    - **Extends the Pandemic EBT program**
        - Makes several changes to the Pandemic-EBT program, which replaces benefits to low income children who have lost access to free or reduced meals at school and child care due to the pandemic
        - Authorizes P-EBT to operate in future school years that are impacted by the COVID-19 pandemic
        - Simplifies and extends P-EBT eligibility for all children eligible for free and reduced-price meals and children in childcare into summer months after a school year in which a public health emergency was in effect at any point in the school year

    - **SNAP Online Purchasing and Technology Modernization**

    - Provides funding for technology improvements in online purchasing, modernization of EBT technology, support for mobile technology demonstration projects, and technical assistance to retailers on online acceptance of SNAP benefits

- **Earned Income Tax Credit (EITC) and Child Tax Credit (CTC) Expansion**
  - Increases the EITC for childless workers by up to $1,000, and expands the minimum and maximum age for claiming the credit in 2021
  - Beginning July 15, 2021 the CTC increases to $3,000 per child age 6-17 ($3,600 for children under age 6) through monthly advance payments for tax year 2021.
  - Provides funding for child care including for financially stressed child care providers for personal protective equipment, rent and mortgage payments, labor costs and other expenses. Additional funding would help subsidize child care costs for eligible families.

Contact Us

If you need to reach any of our ESA Tribal Liaisons, here are the links to our updated Contact lists: DCS Tribal Relations Directory and CSD Tribal Relations Directory.

Washington State Department of Social and Health Services

DIVISION OF CHILD SUPPORT

Life changes, maybe your child support could too!

- Have you changed jobs?
- Are any of your children now over 12?
- Have your child's daycare costs changed?
- Has your income changed?
- Have your child's medical costs changed?
- Have you had another child since the order was created?

If you can answer yes to any of these questions, please contact us for more information. Child support doesn't change automatically with your life changes, but you may request a review of your order. We will send you the necessary paperwork.

Contact us with questions, we are here to help!

Call:
1-800-442-5437

You just need your case number and social security number and the phone system will connect you with your caseworker.

Email:
DCSMods@dshs.wa.gov

Be sure to include your case number.

For more information, please visit our website
www.dshs.wa.gov/dcs

Washington State
Department of Social & Health Services
Transforming lives

Disclaimer: DCS does not provide legal representation to either party in your case and cannot provide you with legal advice.

Washington State Department of Social & Health Services
Transforming lives

INDIAN POLICY ADVISORY COMMITTEE (IPAC)

IPAC Workgroup Tracking

DATE
6/18/21

DSHS LIAISON	PHONE / CELL NUMBER	ADMINISTRATION
Chris Franks **Brittiny Considine**	**(360) 664-5031** **(360) 664-5240**	**Economic Services / Division of Child Support**
TRIBAL CONTACT	PHONE / CELL NUMBER	TRIBE
IPAC		

SUBJECT
Right-Sizing Child Support Orders

SENIOR DIRECTOR, OFFICE OF INDIAN POLICY, ACKNOWLEDGEMENT OF RECEIPT	PHONE / CELL NUMBER
Tim Collins Date Received:	**(360) 902-7816**

Issue

Child support policy and poverty researchers have concluded that orders set too high or too low create barriers to families in their achievement of economic stability and financial self-sufficiency. An order based on improperly imputed income leads to uncollectible debt and does not accurately reflect the income of a parent. Yet, when a parent is voluntarily or involuntarily un- or underemployed, their income is often imputed even when a thorough examination using the factors outlined in RCW 26.19.071 may find that actual income would be appropriate. This more comprehensive analysis is consistent with federal guidance, and the mission, vision, and values of DCS. Administrative child support orders are often initially served or calculated by DCS, but may be determined by an Administrative Law Judge if a hearing is requested. Judicial child support orders are calculated by county prosecutors and are subject to final rulings by a superior court commissioner or elected judge.

Need

Order amounts should reflect the current financial circumstances for both parents and conform to the legal framework set forth in RCW 26.19.071. The process should encourage the critical parental engagement and participation when parent(s) need to request order modification. Education about the process should also be included, with clear guidelines for families who have tribal orders and/or who are receiving services from tribal programs.

Background

Consistent child support payments can be enormously important to household budgeting – especially for lower-income families. DCS began its "Right-Sized Order" project in 2015 and worked to modify state orders on DSHS TANF cases. Next, the project started reviewing orders on non-assistance cases and developed a clear and colorful flyer and supporting documents to help parents understand the modification process. Efforts also include a third phase focused on helping parents stay engaged throughout the modification process utilizing principles of human centered design. DCS also is exploring ways to expand approaches to income determination with an Income Determination Pilot.

Child support in Washington state is set either administratively or judicially as per RCW 26.19.071 / WAC / DCS Policy. The action necessary to modify (or "right size") a court order is different than that of an administrative order, and Tribal orders needing modification have been referred to the establishing tribe for action when necessary.

Action

DCS has so far identified numerous activities necessary to positive results:

- **Use appropriate "income determination" standards when calculating obligations**
- **Communicate proactively**

• Work to engage parents throughout the case so that parents are aware and able to request modification when there is a change of circumstances

• Embrace a family-centered culture that accommodates a variety of circumstances

• Involve partners, clients and stakeholders

• Create a warm handoff for customers who need more assistance

DCS asks:

• Are there tribes whose courts or child support programs assist with "right sizing" orders?

• Are any tribes interested in participating with DCS and other partners/stakeholders in developing better communications/processes for customers?

Next Steps

• Identify further barriers to right-sizing orders.

• Create/identify locations that are welcoming, safe spaces for attorneys or advocates to work with clients

• Educate state and county staff about existing tribal courts and programs

- Tribal sovereignty

- Limitations due to Tribal Code

• Seek tribal input on culturally appropriate language that communicates the process to "right-size" orders

• Include tribes who do NOT operate child support programs to educate their membership about the process