



# State Implementation of ARPA HCBS Spending Plans: Lessons Learned

APRIL 2024



The **ARPA HCBS Technical Assistance Collective** is made up of four organizations with deep expertise in HCBS systems: ADvancing States, Halperin Health Policy Solutions, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), Riverstone Health Advisors, as well as Brian Burwell. The TA Collective's mission is to support states in achieving the objectives included in their ARPA HCBS Spending Plans to expand, enhance and strengthen their HCBS systems by March 31, 2025.

**ADvancing States** represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support long-term services and supports for older adults and individuals with disabilities.

**Halperin Health Policy Solutions** is an independent consulting firm that provides state and federal government agencies, non-profits, and provider organizations with direct assistance related to healthcare and long-term services and supports (LTSS) access and coverage issues for lower-income older adults and persons with disabilities.

**NASDDDS** assists member state agencies in building person-centered and culturally and linguistically appropriate systems of services and supports for people with intellectual and developmental disabilities and their families.

**Riverstone Health Advisors** consults to state and federal agencies, health plans, vendors, and providers as they strive for success in government healthcare programs, including Medicaid home and community based services (HCBS) and other Medicaid long-term services and supports (LTSS) programs, Medicaid managed care, and Veterans' healthcare, among other programs.

**Brian Burwell** is an independent contractor and nationally recognized expert on HCBS policies and programs. He served as a Commissioner on the Medicaid and CHIP Payment and Access Commission for six years. His career has been focused on Medicaid policy for older persons and persons with significant disabilities.

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# Acknowledgments

**A**Dvancing States and our partners with the ARPA HCBS Technical Assistance Collective (TA Collective) are proud to release the final report from our technical assistance efforts supporting states in implementing their ARPA HCBS spending plans. This report, based on states' experiences in implementing their spending plans, provides useful information about specific aspects of that implementation including successes and barriers.

Our admiration and thanks go out to all the states who took the unprecedented federal funds made available under ARPA and turned them into an impressive array of investments which both strengthened and innovated the HCBS system. This feat is even more staggering when they had little to no new human resources and were simultaneously working feverishly to ensure that HCBS recipients received the critical services they needed to continue to live in the setting of their choice.

We are grateful to The John A. Hartford Foundation, The Care and Respect with Equity for All (CARE) Fund, The SCAN Foundation, and the Milbank Memorial Fund for supporting this work.

The HCBS system is facing more challenges than ever before. Our hope is that the insights and findings from the states will help guide any future federal investment in our HCBS system.

Sincerely,



**Martha Roherty, Executive Director**  
*ADvancing States*



# Executive Summary

Section 9817 of the American Rescue Plan Act (ARPA) authorized an unprecedented federal investment in Medicaid home and community-based services (HCBS), currently estimated at \$37 billion. States that wished to access these funds had to act within a short timeframe to identify and implement projects that would expand, enhance and strengthen HCBS. States outlined these projects in ARPA HCBS spending plans, which were subject to approval by the Centers for Medicare & Medicaid Services (CMS). Included in these spending plans were more than 900 projects. Numerous projects were aimed at addressing emergent challenges in HCBS, while many focused on bringing about HCBS innovation. Over the course of implementation, states made critical decisions to retool projects or even cancel efforts for a variety of reasons. An assessment of the process by which states engaged in those activities could inform future federal investments in HCBS.

In early 2024, the ARPA HCBS Technical Assistance (TA) Collective conducted a survey of the states and territories to elicit information on their experience with trying to implement their original proposed ARPA HCBS spending plans. Thirty-three states responded to the survey and provided information about:

- The number of ARPA HCBS spending plan initiatives proposed and those which were either terminated or actually implemented;
- The type and frequency of delays which hampered effective implementation; and
- The date they expect to have fully expended their ARPA HCBS funds.

Where the responding states indicated that they did need to terminate or otherwise modify some of the projects included in their original spending plan, they shared the top barriers to implementing their projects as planned. These barriers include:

- Delays in obtaining approval from CMS for both their spending plans and the necessary federal authorities to implement those plans;
- Lack of staff capacity to design and implement complex initiatives;
- The time it takes to complete state procurement processes in order to implement projects; and
- The need to secure legislative approval and/or budget authority before beginning work.

The TA Collective suggests ways to make any future time-limited investments in the HCBS system more effective, including giving states more time to implement, easing the CMS approval process and providing resources to both states and CMS. Moreover, any future investments should be accompanied by a federal evaluation to glean insights into successful interventions that could be replicated across the country.

While this report highlights challenges and lessons learned, it should be noted that, against all odds, states created transformational change with their ARPA spending plan initiatives.

# Introduction and Background

Americans' average life expectancy has been increasing. More Americans are living longer, and living with physical, intellectual and developmental disabilities (I/DD), dementia, and other conditions. Consequently, Americans increasingly rely upon Medicaid, our nation's primary payor of long-term services and supports (LTSS). Through Medicaid, states have long been required to cover facility-based LTSS, most often in the form of nursing homes. In contrast, coverage of HCBS LTSS is optional for states, and the extent of HCBS programs varies significantly from state to state.

More than 75% of older adults wish to remain in their communities as they age. In 2013, for the first time in our nation's history, more than half of all Medicaid LTSS expenditures were for HCBS LTSS services while less than half were for facility-based LTSS. Today, approximately 63% of total state Medicaid LTSS expenditures are for HCBS.<sup>1</sup>

While much has been accomplished to expand and strengthen our HCBS delivery systems during the last several decades, it is not enough. Many older adults and people with physical disabilities could be served in HCBS settings rather than nursing facilities. For adults with I/DD, many national leaders assert that all services should be provided in a home or community-based setting. Not only are HCBS settings what people want, HCBS settings also are less costly than facility settings. The existing HCBS system, however, is not robust enough to meet the current demand, and is poorly positioned to meet increasing and future needs of people who are living longer and living with disabilities. Clearly, investments in the HCBS infrastructure and rebalancing of the LTSS system are needed. These needs were recognized by national policymakers prior to the Public Health Emergency (PHE) and resulted in a variety of proposals to invest in our nation's HCBS delivery systems. They included:

- Direct care workforce supports;
- Deploying enabling technology;
- Building expanded behavioral health supports to HCBS participants;
- Quality systems improvements;
- Case management and critical incident management systems investments;
- Caregiver supports, and
- Provider innovation pilots.

**More Americans  
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<sup>1</sup> <https://www.medicaid.gov/media/164316>

While these proposals did not pass into law before the PHE, they were on the minds of many state and national HCBS leaders when the legislative priorities shifted to address the pandemic response.

Partly in recognition of the tragic disproportional impact of COVID-19 on older adults and individuals with disabilities, the high number of deaths in institutional settings, and the related demands and accompanying challenges, Congress enacted the American Rescue Plan Act (ARPA) of 2021. Section 9817 of ARPA provided additional federal funding for HCBS, which was projected to result in over \$25 billion of total spending to expand HCBS services and infrastructure. Current projections from CMS place total ARPA HCBS spending at \$37 billion.<sup>2</sup> The purpose of these funds was to enable states to expand, enhance and strengthen HCBS and, coupled with the flexibilities permitted under the PHE, they enabled states to ignite innovation in HCBS service delivery.

Spring 2021 brought the opportunity for states to develop and submit proposed ARPA HCBS spending plans. The ARPA HCBS funding opportunity was viewed by states as too big of an opportunity to forgo. Every state and territory elected to pursue the enhanced funding and, therefore, acted quickly to respond to CMS within approximately ten weeks (extended from the original 30-day timeframe). This short deadline created a circumstance where states had to furiously grab at any innovative new ideas they could identify, many of which were previously un- or under-tested. States submitted their proposed plans and then waited, while CMS reviewed, revised, and approved some or all of each state’s initiatives. Every state participated. Over 900 total initiatives were proposed. **Figure 1** below summarizes states’ initiatives.

**Figure 1. Number of States’ ARPA HCBS Spending Plan Initiatives, by Type of Initiative**

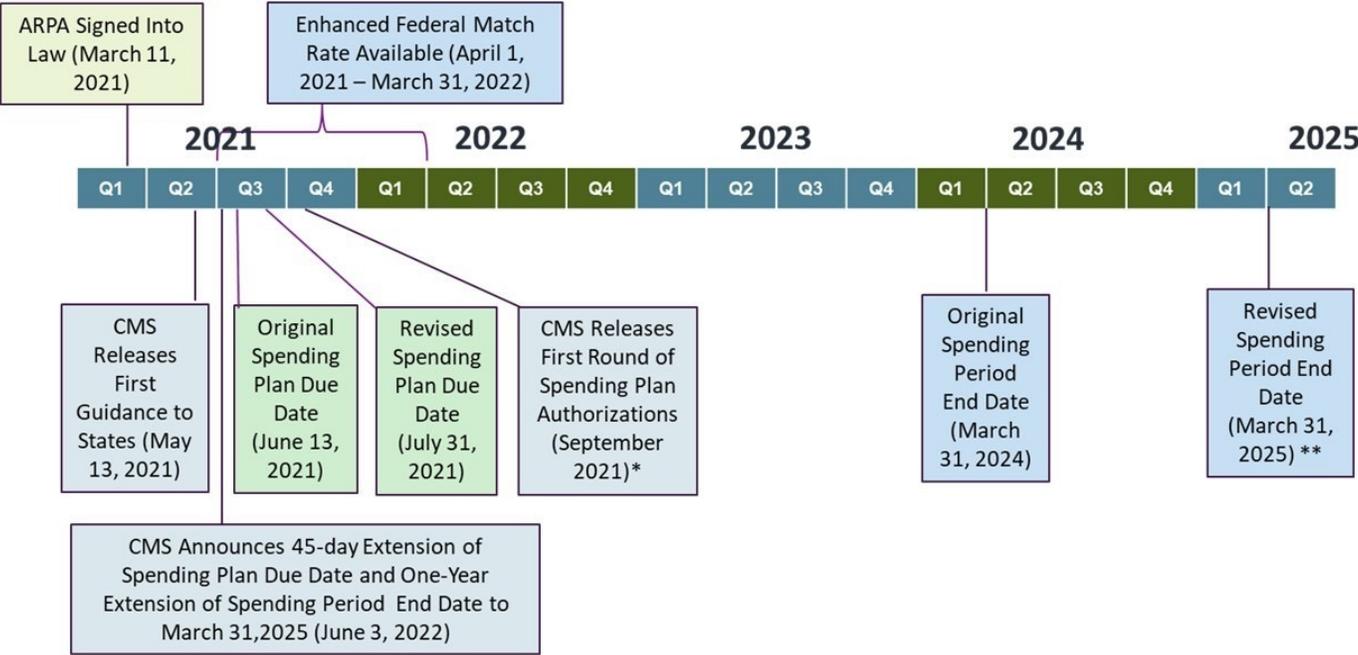
Category of Initiatives	Number of Initiatives
Added or Expanded Services	167
Administrative Activities	132
Provider Recruitment Training	128
Provider Payment	121
Other Initiatives	106
Technology for States	83
Eligibility and Enrollment	70
Technology for Providers	45
Quality	42
Capital Improvement	28
<b>Total</b>	<b>922</b>

<sup>2</sup> <https://www.medicaid.gov/medicaid/home-community-based-services/guidance-additional-resources/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html>

A more extensive summary of ARPA HCBS Initiatives can be found [here](#). These far-reaching initiatives include some of the most creative and innovative investments in the history of our nation’s HCBS delivery system and in many cases have saved lives and improved quality of life for individuals who participate in HCBS programs.

The statutory and CMS requirements for ARPA HCBS spending plans were minimal. States were obligated to create new initiatives, comply with a maintenance of effort (MOE) requirement, submit quarterly progress and spending reports, and spend all the dollars for their approved initiatives by March 31, 2024. [Note: States were later offered the option to extend the deadline to March 31, 2025, and recently a handful of states have received approval from CMS to continue spending beyond that date.] States were not required to have fully formed, executable plans for implementing their ARPA HCBS spending plan initiatives. The timeline for proposing, designing, and implementing their ARPA HCBS initiatives, which has proven challenging for state governments to meet, served to further hinder states’ ability to design and execute useful evaluations. **Figure 2** highlights the key milestones in that timeline.

**Figure 2. ARPA HCBS Spending Plan Implementation: Federal Timeline**



\*Note: Subsequent authorizations were issued piecemeal, and timing of authorizations in relation to submission date was generally not predictable  
 \*\*Note: States can request an extension of this date

# Purpose of Report/Methodology

To gather insights into states' experiences in implementing their ARPA HCBS spending plans, the ARPA HCBS TA Collective (the Collective) fielded a national survey between December 2023 and February 2024. This survey aimed to identify successful strategies used by states implementing their ARPA HCBS spending plans, as well as any barriers hindering their success. The survey explored key aspects of state implementation efforts, including details about each state's initial spending plan; anticipated timelines for spending all allocated ARPA HCBS funds; the timing of implementing specific initiatives and the considerations influencing those timelines; and opportunities for states to share valuable lessons learned throughout the process. Thirty-three states participated in the survey. While this represents a 65% response rate, we feel confident to draw conclusions that are broadly applicable to states' experiences. The information gathered from the survey forms the basis of many of the trends and analyses presented in this paper.

Additionally, this report is informed by the Collective's work supporting states with their ARPA initiative planning, implementation, and evaluation activities and by our observations and analysis of state and federal ARPA HCBS activities. It builds upon the Collective's past work including, [Efforts to Evaluate the Impact of ARPA HCBS Investments](#), an issue brief examining state evaluation approaches, and a summary of the work of the HCBS Sustainability Summit, which provided valuable context on sustaining the HCBS commitment fostered by ARPA investments. Both reports can be found [here](#).

**The results presented here offer a critical, real-time assessment of state ARPA HCBS initiatives.**

Analyzing states' survey responses in the context of the Collective's broader experience enables the identification of key themes and trends that contributed to the successful implementation of ARPA HCBS spending plans, as well as factors that limited states' ability to maximize the potential of ARPA HCBS funding. First, the report presents an overview of the ARPA HCBS endeavor, outlining CMS requirements, timeframes, and providing insights into states' innovative utilization of ARPA dollars. Following this, the report analyzes trends in state implementation experiences. This analysis leverages survey data to explore how factors like spending

plans changes, approval and implementation delays, expenditure deadlines, and states' nimbleness have impacted state utilization of ARPA HCBS funding. Finally, drawing upon these lessons learned, the report offers recommendations for future federal investments, aiming to ensure the success and sustainability of HCBS systems nationwide. The results presented here offer a critical, real-time assessment of state ARPA HCBS initiatives. This information can be particularly valuable for states seeking to expedite the expenditure of their remaining ARPA HCBS funds, given the dearth of other sources of consolidated state experience data to date.

# Survey Results

## Initial Spending Plan Initiatives

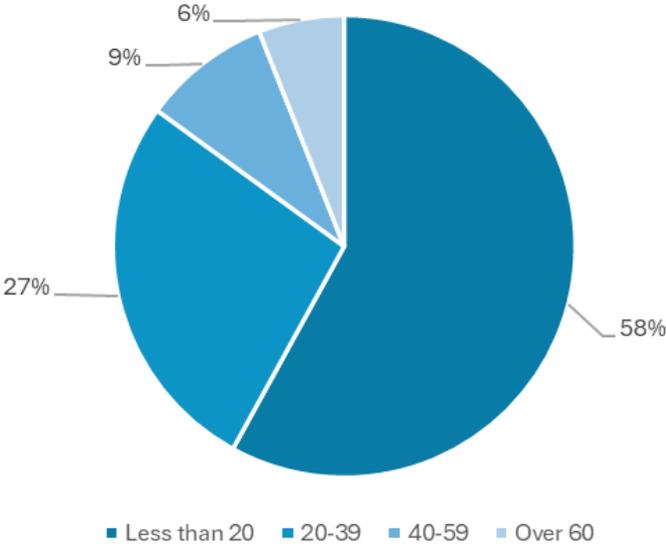
The survey asked states to report on the total number of initiatives they submitted in their initial ARPA HCBS spending plans and to provide counts by the following subcategories:

- Implemented as proposed (timeframe changes should be included in this response)
- Implemented but with modification (other than timeframes)
- Eliminated entirely from your state’s ARPA HCBS spending plan
- Still waiting for action
- Other

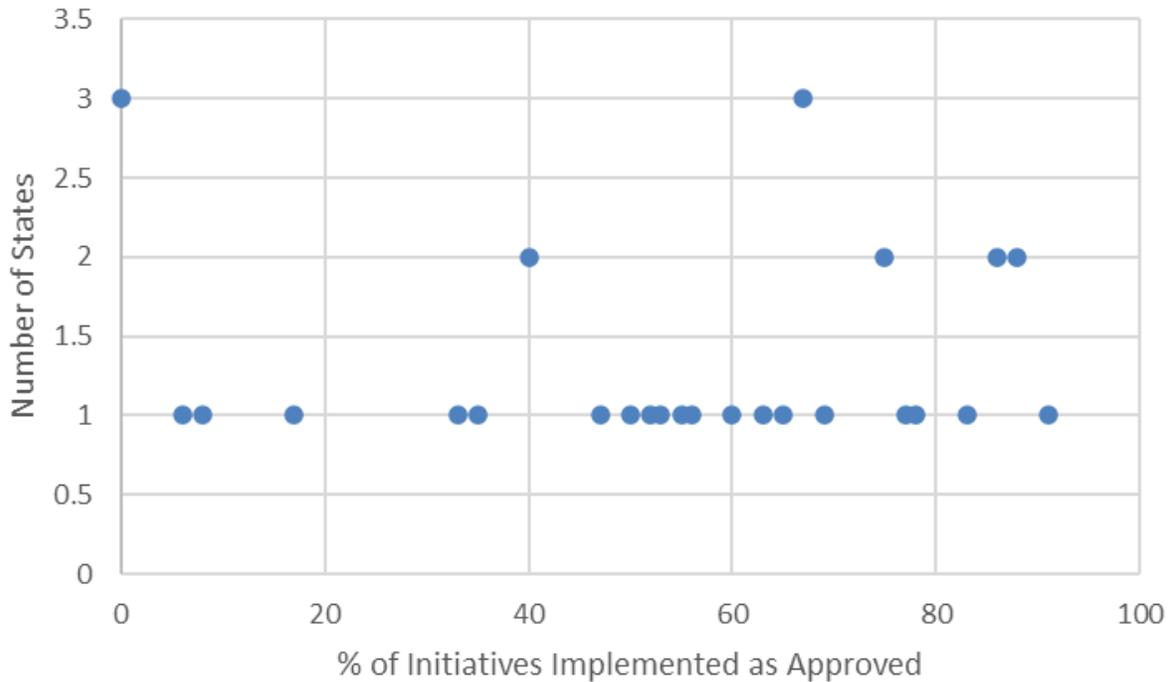
States varied greatly in the number of initiatives they proposed in their original ARPA HCBS spending plans. Among the 33 states that participated in the survey, the total number of initiatives a state had ranged from 1–72. Most reporting states (58%) included fewer than 20 initiatives in their original spending plans, 27% included 20–39 initiatives, 9% included 40–59 and 6% included 60 initiatives or more in their original spending plan. **Figure 3** displays this data.

Despite the short timeframe within which states had to identify proposed initiatives to CMS in their original spending plans, thirty states (91%) were able to implement one or more of the initiatives identified in their original spending plan. In fact, a large majority of the states (67%) reported success in implementing 50% or more of their original spending plan initiatives. Only three states (9%) were unable to implement any of the initiatives proposed in their initial spending plans.

**Figure 3. Distribution of States Based on the Total Number of Initiatives Included in the State’s Original ARPA HCBS Spending Plans**



**Figure 4. Number of States by the Percentage of Initial Spending Plan Initiatives Implemented as Proposed**



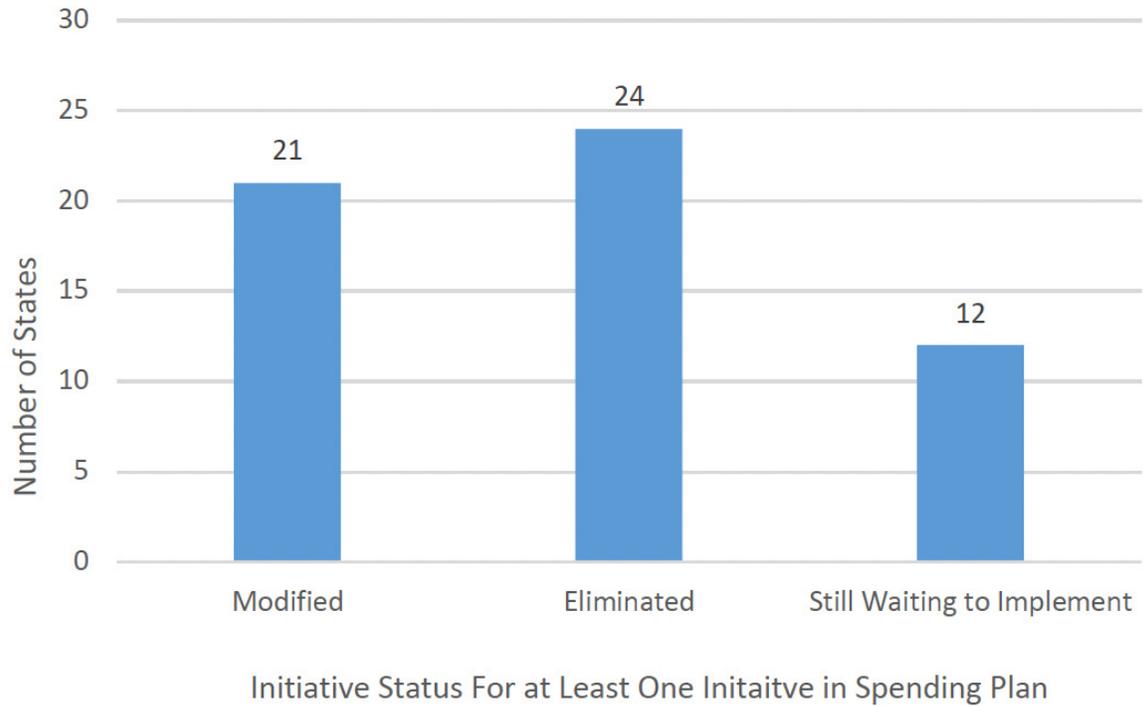
While a majority of states experienced some success implementing initiatives as originally proposed (aside from timeframe extensions), experience varied greatly by state. For example, of the two states with the greatest number of proposed initiatives in their original spending plans, one state implemented 88% of its initiatives as planned while the other implemented only 8% of its initiatives as originally planned.

The percentage of state initiatives implemented as proposed in the state’s original spending plan (**Figure 4**) ranged from 0–91%, further illustrating the wide variation in ARPA HCBS experiences across states.

## Spending Plan Initiative Changes

All responding states modified or eliminated at least one of the initiatives in their initial spending plan (**Figure 5**). Twenty-one states modified at least one initiative, and 24 states eliminated at least one initiative. Twelve states reported they were waiting for action to implement at least one of the initiatives, so it is unknown whether those states will implement these initiatives as planned or with changes, or whether the states have sufficient time to implement these initiatives.

**Figure 5. Number of States that Reported Having to Modify, Eliminate, or are Still Waiting to Implement at Least One of Their Initial Spending Plan Initiatives**

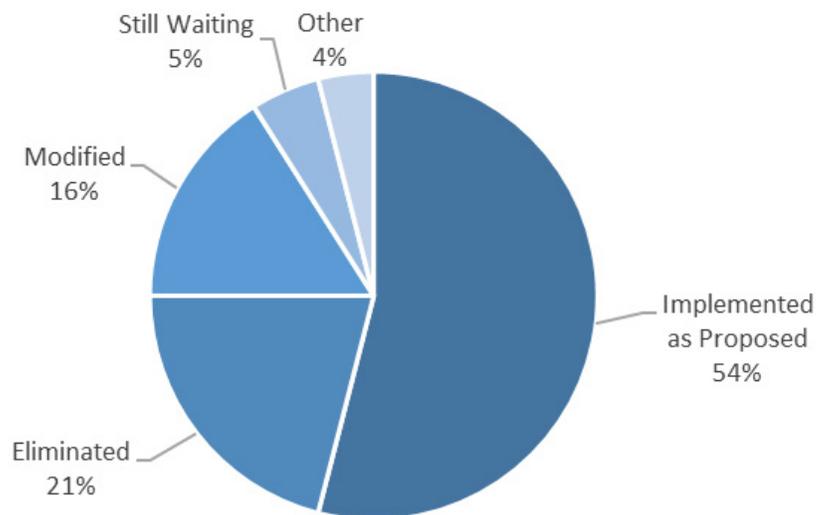


Altogether, the 33 participating states’ initial ARPA HCBS Spending Plans included a total of 768 initiatives. When asked to identify whether they implemented the initiatives as proposed or with modification, the participating states said that they:

- Implemented the majority (54%) of initiatives as proposed;
- Eliminated 21% of original initiatives entirely;
- Implemented 16% with modifications;
- Had not yet implemented 5% of their initiatives.

Four percent of the responding states replied “other” as the reason for being unable to implement according to the original plan. (**Figure 6**)

**Figure 6. Percentage of Initial ARPA Spending Plan Initiatives by Current Status**



## Eliminated Initiatives

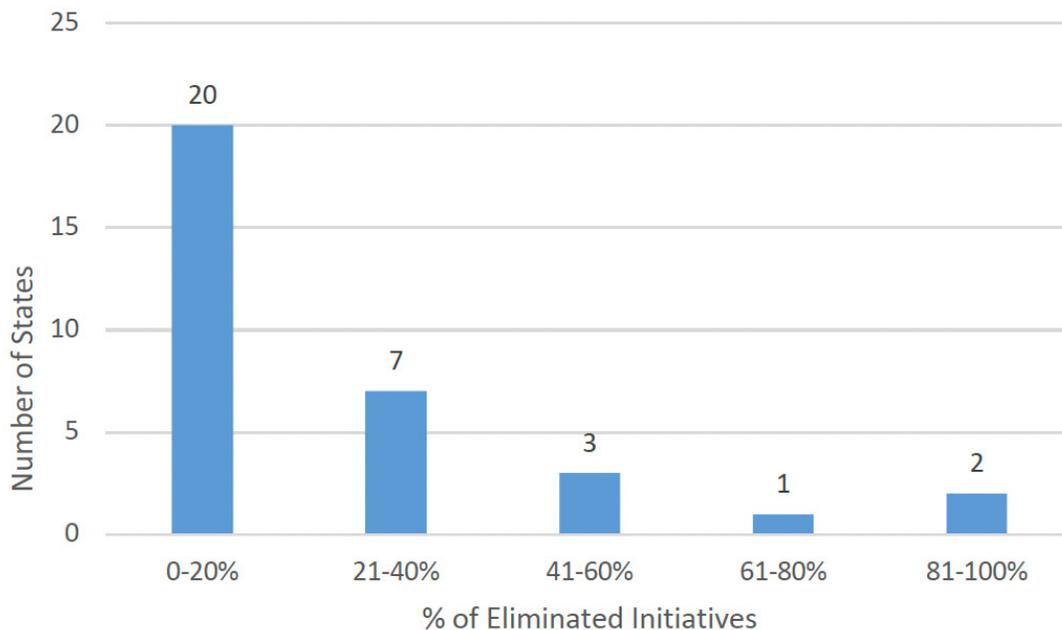
The survey asked states whether they eliminated any initiatives entirely from their initial ARPA spending plan. If they responded in the affirmative, the survey then asked states to indicate the reason why from a list of the following list (respondents could select more than one reason):

- Did not receive legislative approval or legislature directed agency to use ARPA funds for the project
- Did not receive CMS approval to use ARPA funds for the project
- Stakeholder feedback
- Internal workload constraints
- Encountered unanticipated complications
- Other – write in response

Seventy-three percent of responding states (24) had to eliminate at least one initiative from their spending plan while nine states did not eliminate any of their initiatives.

Overall, the percentage of initial spending plan initiatives that states had to eliminate varied greatly. **Figure 7** shows that most states had to eliminate 20% or fewer of the total initiatives from their plans. However, a few states (3), had to eliminate more than 75% of their initial initiatives. One state had to eliminate all their initial initiatives because they were given a legislative directive to use all the ARPA funding for provider rate increases after submitting their original spending plan to CMS.

**Figure 7. Number of States by Percentage of Initiatives Eliminated**

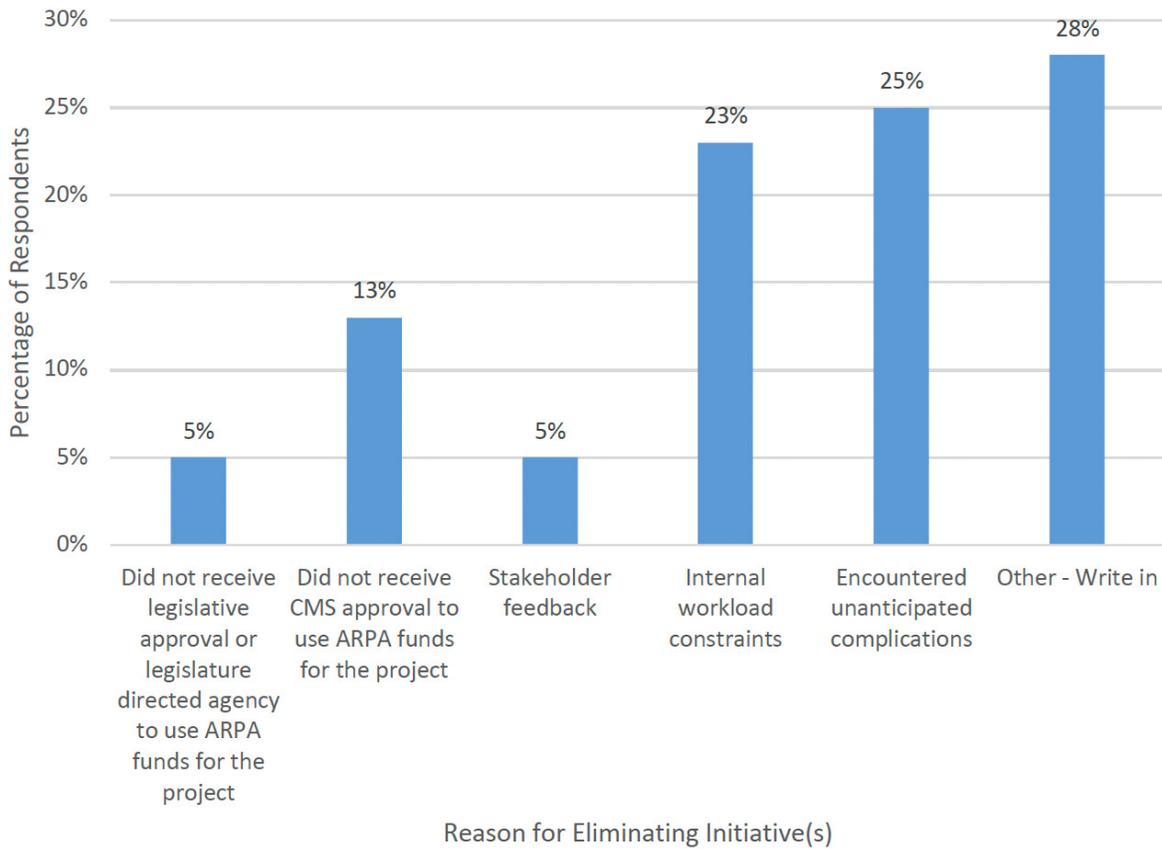


Workload constraints and unanticipated complications were the most common reasons for eliminating initiatives. Other reasons included:

- States obtaining funding from different sources (e.g. state budget or legislation, grants);
- Initiatives being incorporated into other projects and programs; and
- Situational changes leading to the initiative no longer being necessary.

**Figure 8** below depicts states’ reported reasons for eliminating ARPA HCBS initiatives and the frequency for each of the reasons.

**Figure 8. Percentage of States Who Eliminated an ARPA HCBS Initiative for the Reasons Identified**



## Key Takeaways from States Who Eliminated Initiatives from Their Original Spending Plans

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As states looked to implement multiple initiatives swiftly and simultaneously, it is unsurprising that some original initiatives might not be implemented as planned or identified. For some states, the elimination of one or more initiatives was the result of legislative or CMS directive, including the state identified above. For other states, reasons that original initiatives were eliminated include staffing, administrative burden, and complexity of initiative design. One state reported that it technically eliminated some of its initial standalone initiatives by merging the work and effort into other ARPA projects.

State agencies that operate HCBS programs had to conceptualize and effectuate their state's ARPA HCBS spending plan while still accomplishing their agencies ongoing, preexisting, and significant workload. All but a few of the states responding to the survey reported that they did not receive any additional human resources to implement their ARPA spending plan. Those staffing constraints, along with the demands of managing service delivery during a PHE, resulted in struggles to carry out the necessary design and implementation phases required to implement new initiatives under tight time constraints. A handful of states were able to contract for consultants to help with substantive work, which better positioned them.

States indicated operational complexities resulted in the elimination of some of their original initiatives. They also eliminated initiatives because they received legislative funding or separate funding outside of ARPA for the project; in other words, the states implemented the initiatives, but used non-ARPA dollars to fund the initiatives.

## Spending Plan Implementation Delays

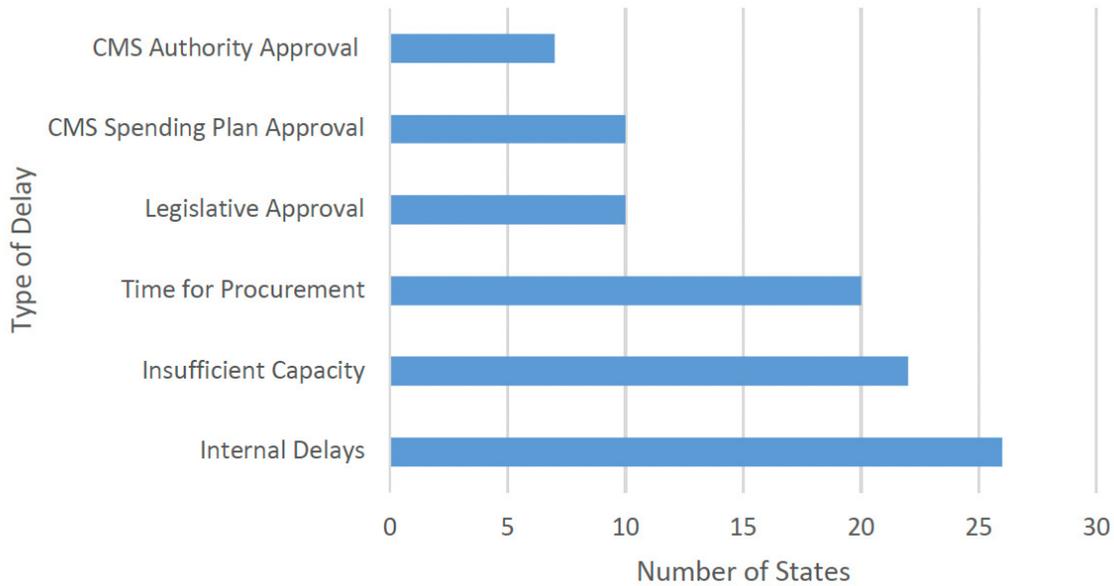
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The survey asked states if they experienced delays in implementing ARPA initiatives (**Figure 9.1**). If they responded in the affirmative, it asked them to indicate the reason from the following list:

- Delays in obtaining final CMS spending plan approval for some or all initiatives. (**Figure 9.2**).
- Delays in obtaining CMS approval for authority to implement. If yes, indicate the type(s) of barriers you encountered obtaining CMS approval (**Figure 9.3**):
  - > Medicaid Authority Approvals (1915(c), SPAs, etc.)
  - > Administrative Claiming approvals
  - > Advanced Planning Document approvals
  - > Other
- Internal delays in designing new initiatives and getting them off the ground (**Figure 9.4**).
- Insufficient staffing capacity to get all the work done (**Figure 9.5**). If yes, how were these insufficient staffing capacity issues resolved.
- Extended time needed to execute ARPA HCBS-related procurements. If yes, average length of time to execute necessary procurement (**Figure 9.6**).
- Need to secure legislative approval before starting new initiatives. If yes, how long were the delays (**Figure 9.7**).
- Other reasons for delay

Twenty-seven states (82%) reported delays in implementing their ARPA HCBS initiatives. The top reasons cited for delays are included below.

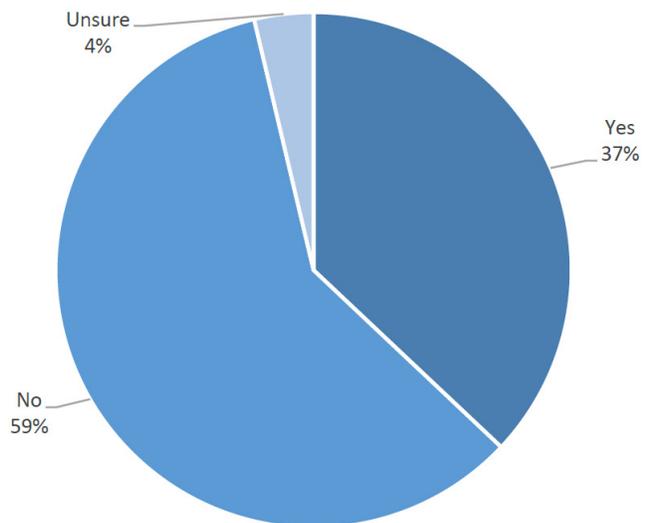
**Figure 9.1. Reasons States Reported Delays in Implementing Initiatives in Their Original Spending Plan**



Figures 9.2 through 9.7 describe more about states’ experiences with each of these six types of delays.

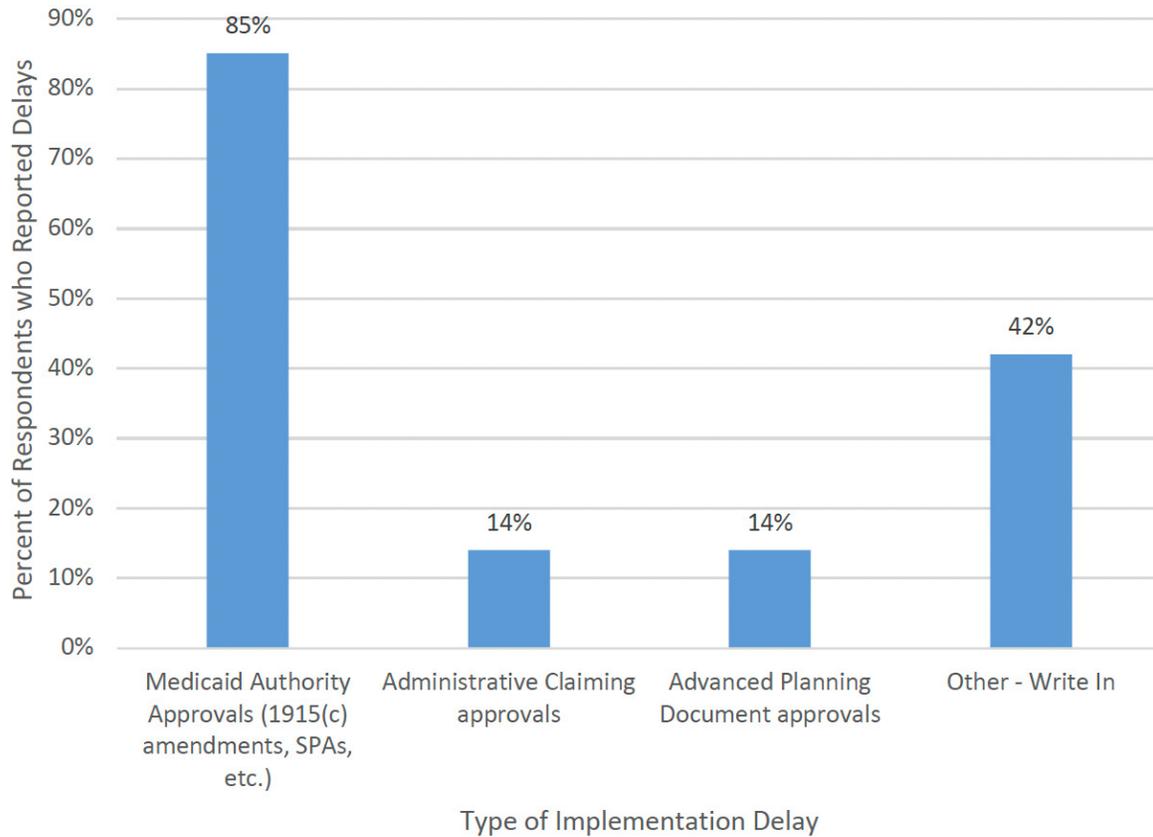
States reported a myriad of reasons for delays attributed to CMS spending plan approval (Figure 9.2). Often, delays in CMS approval required corresponding changes to initiatives in the state’s original plan because the timeframe states indicated in their original plan could no longer be met. A few states reported that they did not have clear direction from CMS on the CMS-64 reporting requirements, which caused delays due to uncertainty about total funding availability. The ongoing negotiations with CMS, either for approval of their spending plans and/or responding to CMS requests for additional information about their spending plans, also caused delays in implementation. States also indicated they had to submit corresponding

**Figure 9.2. States Experiencing Delays in Obtaining Final CMS Spending Plan Approval for Some or All Initiatives**



waiver changes prior to the execution of their ARPA initiatives, which caused implementation delays.

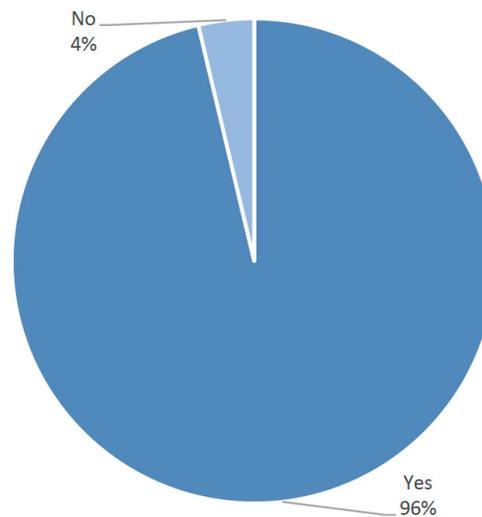
**Figure 9.3. Percent of States that Reported Delays Due to Obtaining Federal Authority Approvals by Authority Type**



The overwhelming reason for delays in obtaining CMS approval was navigating the authority approval process. (Figure 9.3). CMS approvals likely would have caused further delays, had the ARPA HCBS spending period not overlapped with the PHE. Due to the PHE, CMS was more expeditious in its review of state requests and was more flexible regarding what it would approve.

Far and away the most common reason reported by responding states for APRA HCBS spending plan implementation delays was the slow start to designing and initiating new initiatives (Figure 9.4). States that indicated a slow start as a reason for implementation delay were asked to identify the top reasons for the slow start. The two most common

**Figure 9.4. Percent of States Experiencing Delays Due to Designing and Starting One or More ARPA-HCBS Initiatives**



reasons reported by states were insufficient staffing capacity (82%) and extended time needed to execute ARPA HCBS-related procurements (74%).

More detailed information on these reasons is displayed in **Figures 9.5** through **9.7** below. Reported delays also included:

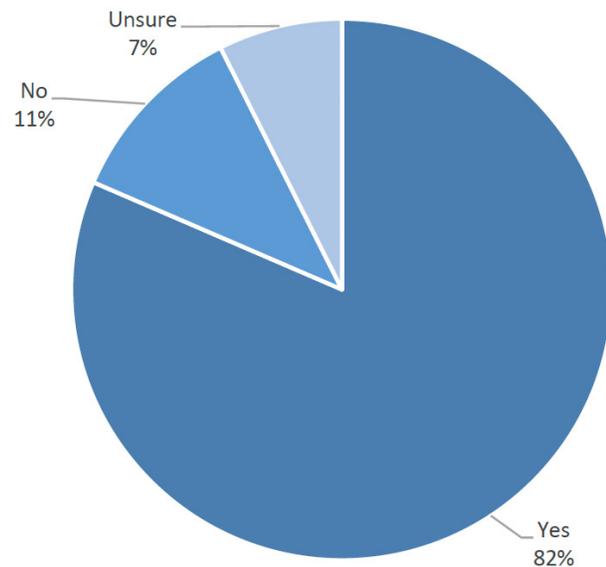
- Obtaining and incorporating stakeholder feedback;
- Internal vetting;
- State approval processes;
- The lack of clear guidance on CMS-64 claiming which caused duplicative work;
- Receiving legislative approval;
- Change in leadership;
- Staff turnover;
- Identifying contractors to support the work; and
- Lack of technology.

Some states that reported insufficient staffing as a barrier (**Figure 9.5**) also using ARPA funding to hire additional staff but noted that hiring staff took significant time. Other states used existing staff and re-prioritized and re-organized work, which also took time to orchestrate. States also reported staff turnover as a significant contributor to delays. A few states saw success when they contracted or outsourced some of the project work, but this also took time to implement.

States frequently cited procurement as a reason for delays in implementing ARPA projects (**Figure 9.6**). Seventy-four percent of responding states needed extended time to execute ARPA HCBS-related procurement while 11% of states were unsure or did not know if there were procurement delays and 15% of states had no procurement delays.

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**Figure 9.5 States Experiencing Delays Due to Insufficient Staffing Capacity to Complete All ARPA-HCBS Initiative Work**



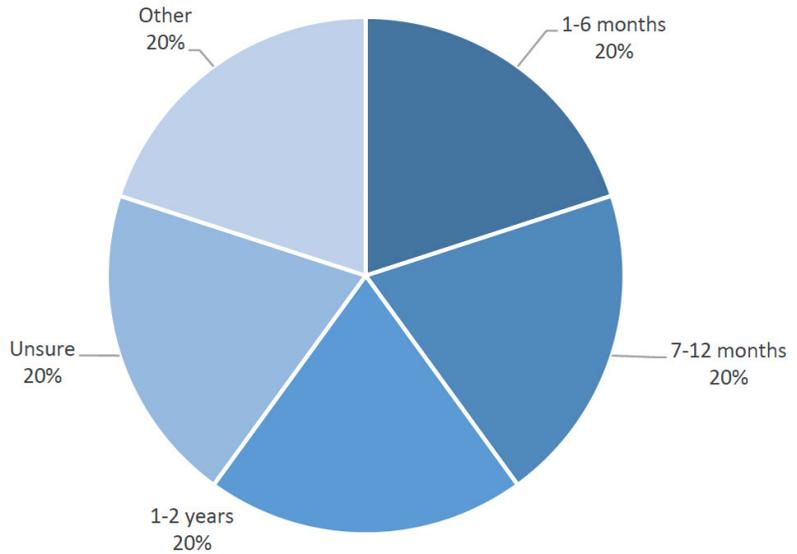
Timeframes varied widely and were dependent on the type of project. One state indicated that they are still working through procurement processes for some initiatives. Another state captured the procurement process complexity with this comment:

“The timeline really depended on the type of procurement for the project. We had purchase orders, vendor contracts, requests for proposals, grants, and ITNs. So the timeline ranged significantly (anywhere from 3 months to over a year). We currently have over 1,000 grant agreements in place and over 70 contracts that are all supporting the ARPA HCBS work.”

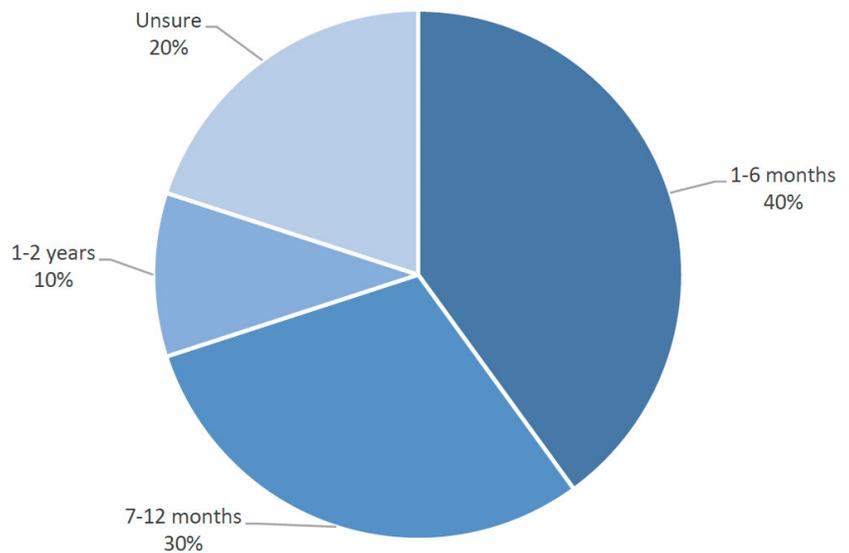
States that responded “other” to this survey question commented that the time needed to execute necessary procurements depended on the project and type of procurement activity.

Finally, states cited approval from a state’s legislative body as a third significant factor in implementation delays (**Figure 9.7**). About 1/3 of the responding states indicated that they could not proceed with implementation without legislative approval. Of those states, almost 40% said the delays added anywhere from 7 months to two years to the state’s implementation timeline.

**Figure 9.6 Extent of Delays Encountered by States that Experienced Delays Due to Time Needed to Execute ARPA HCBS-related Procurement**



**Figure 9.7 Extent of States’ Delays Due to Securing Legislative Approval to Begin Implementation**



## Key Takeaways from ARPA HCBS Spending Plan Implementation Delays

Procurement and staffing capacity were the leading causes of spending plan implementation delays. Nearly all states (96%) indicated that they experienced internal delays when designing and starting new initiatives; 82% of states reported that they had insufficient staffing capacity to complete necessary work; and 76% indicated delays due to HCBS procurement processes. The next most cited reason for implementation delays were delays in obtaining final CMS spending plan approval (37%) and securing legislative approval (37%).

For one state, the issues were complex and varied:

“Standing up the ARPA HCBS initiatives required a lot of work while the state also managed the end of the COVID-19 PHE and Medicaid unwind. This, combined with staff turnover, has created a situation where staff have been stretched thin. Additionally, we faced delays in obtaining materials due to global supply chain issues.”

Although most states reported needing more time to execute ARPA HCBS-related procurements than originally anticipated, the average time needed to execute these procurements varied significantly by state, and initiative. State responses also indicated the considerable challenge of navigating administrative processes, especially with initiatives that crossed multiple service arenas and state agencies.

Another state noted:

“A number of our projects include collaboration with one or more other state entities, including the state’s BH/DD agency, child welfare agency, and housing agency. Internal issues at those agencies often resulted in delays with projects, which in some cases resulted in the project being removed from the plan. Outside vendors have also caused delays, especially with regards to IT vendors as they have fallen behind with their own proposed/contracted design and implementation plan timeframes.”



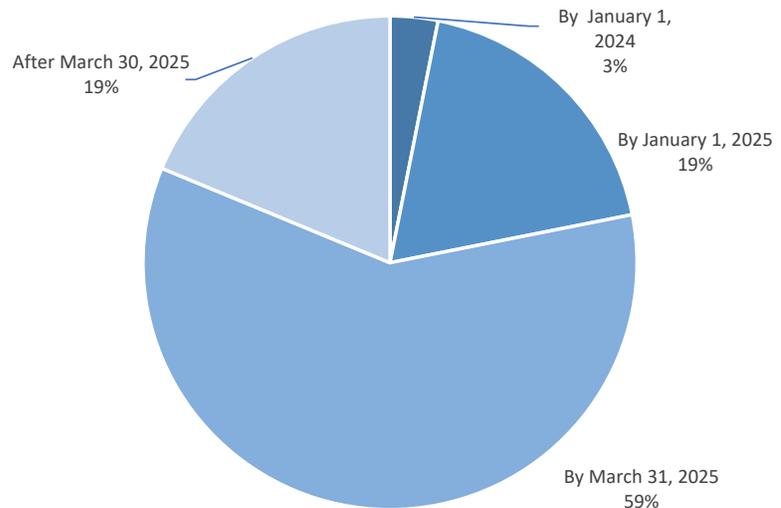
## States' Anticipated Date to Fully Expend ARPA HCBS Funds

The survey asked states to select the date they anticipate concluding their ARPA HCBS Spending initiatives (Figure 10) from the following:

- By January 1, 2024
- By January 1, 2025
- By March 30, 2025
- After March 30, 2025

Despite delays in spending plan approval, the majority (81%) of states reported that they anticipate completing their ARPA HCBS spending by the March 30, 2025 deadline. Only one responding state indicated that it had already completed its ARPA HCBS spending; in contrast, only 19% of the states anticipate extending work on initiatives beyond March 30, 2025.

**Figure 10. Distribution of States Based on State's Anticipated Date for Fully Expend ARPA HCBS Funds**



## Initiatives States Were Most Able to Implement Quickly

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The survey asked states to identify any ARPA HCBS initiatives that they were able to implement within a short timeframe (i.e., in one year or less from the date on which CMS approved the initiative). For the purpose of this report, we are calling these “quick hit” initiatives.

The types of “quick hit” initiatives states most frequently identified included:

- Rate increases;
- Wage bonuses (direct care worker and case management);
- One-time supplemental payments;
- Direct care workforce one-time retention bonuses; and
- Targeted pilots with limited scope.

Types of “quick hit” initiatives that states identified less frequently included:

- Home modifications;
- Customer Experience Tool;
- Enabling technology;
- Institutional diversion activities;
- System upgrades – case management, critical incident and EVV;
- LTSS strategic planning study; and
- Person-centered planning grants.

## Key Takeaways for Implementation Feasibility

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The survey asked states to reflect on the ARPA HCBS spending plan process and lessons learned. Many states reported their greatest success started with initiatives that were in existing strategic plans, were already vetted with stakeholders, and/or had pre-existing funding mechanisms. While any of these three pre-existing conditions could support a state’s success, combined they were particularly effective, as one state noted:

“In several instances, we utilized an existing strategic plan with detailed action steps which made decisions about directing funds relatively easy because stakeholder priorities were clear and had been previously adopted. This, in combination with having the appropriate payment mechanisms available, helped to shorten the runway for several of the activities included in our approved spending plan, which proved critical in getting activities off the ground quickly.”

States also shared that it was important to utilize project planning tools and management strategies at the get-go and throughout the implementation process. Often, the initiatives were complex and required a robust communication and project management plan to ensure effective implementation.

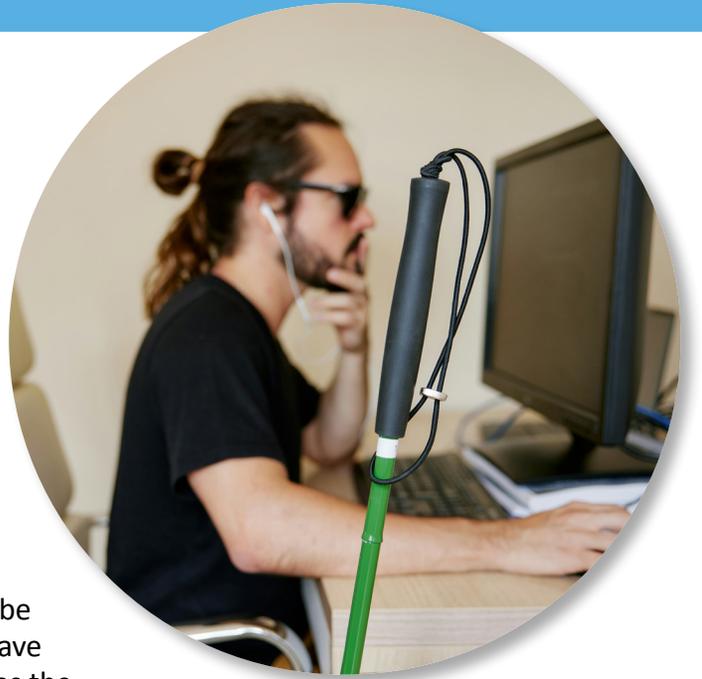
Cross-collaboration with participating agencies and community organizations was also referenced as critical to initiative implementation and success. Finally, states shared that ongoing stakeholder engagement and provider buy-in was critical to initiative success.

# Using Survey Results to Inform Future Policy

The Collective identified four critical elements of the ARPA HCBS spending plan process and implementation activities that could inform future federal investments in the HCBS system.

1. States need ample time to develop a spending plan with meaningful stakeholder input, including legislative bodies. It was clear that ten weeks is not enough time for most states to be thoughtful and strategic in determining where to invest these additional federal funds.
2. States' budget and legislative cycles, as well as the complexities of state procurement processes, should be considered when deciding the length of time states have to fully expend the additional federal dollars, as well as the start and stop dates.
3. States need a strong partnership with the federal government under these circumstances to assure that project reviews minimize administrative burden and expedite approvals. The flexibility afforded under the PHE for federal authority approvals is an outstanding example of this type of support needed by states.
4. Both states and CMS need administrative funding to support the development and implementation of systemic improvements. Delays on the front end due to limited staffing resources at CMS to support review and approval of ARPA HCBS spending plans, as well as staffing constraints at the state on the implementation end combined to delay some states' project by months.

Additionally, while not probed with states as part of this survey, the Collective's prior work highlights the need for evaluating such a significant investment of federal dollars. The Collective previously surveyed states about their work to evaluate the impact of ARPA HCBS investments and made recommendations related to evaluation. Among them, the Collective noted that it is imperative that any future investments in HCBS be accompanied by a national evaluation of interventions and successful outcomes.



# Conclusion

Despite the challenges states faced implementing their initial spending plan initiatives, states demonstrated creativity, collaboration, perseverance, and adaptability to design and implement effective initiatives. The funding provided a unique and rare opportunity for states to enhance HCBS services. It was a herculean effort while simultaneously addressing the significant impacts of the PHE on their HCBS recipients. The learning that occurred leaves the states well-positioned to take advantage of any future federal investments in HCBS. As one state reported “[we are] so very thankful for these funds and the ability to improve the quality of life of individuals with disabilities... [we did] things I have always dreamed about in my 32 years of experience in the field.”





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