Efforts to Evaluate the Impact of ARPA HCBS Investments

JANUARY 2024

ADVANCING STATES

ARPA HCBS
Technical Assistance Collective

Table of Contents

Efforts to Evaluate the Impact of ARPA HCBS Investments

JANUARY 2024

AUTHORS

Alissa Halperin, Halperin Health Policy Solutions

Anne Jacobs, Riverstone Health Advisors

The ARPA HCBS Technical Assistance Collective is made up of four organizations with deep expertise in HCBS systems: ADvancing States, Halperin Health Polcy Solutions, the National Association of State Directors of Developmental Disability 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.
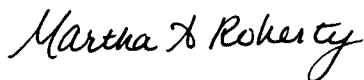
Brian Burwell is an independent contractor and nationally recognized expert on HCBS policies and programs. He served as a Commissioner on the Medicaid and CHIP Payment and Access Commission for six years. His career has been focused on Medicaid policy for older persons and persons with significant disabilities.

Acknowledgments

ADvancing States and our partners with the ARPA HCBS Technical Assistance Collective (TA Collective) are proud to release this paper that provides important and timely information about states' efforts to evaluate the impact of their American Rescue Plan Act (ARPA) home and community-based services (HCBS) initiatives and investments. Through the generous support of The John A. Hartford Foundation, The Care and Respect with Equity for All (CARE) Fund, The SCAN Foundation, and the Milbank Memorial Fund, the TA Collective conducted a state survey and focus groups to identify states that, relative to other states, demonstrated progress with planning for and conducting evaluation of their ARPA HCBS initiatives. We are grateful to these foundations for their support and to the state officials who shared their expertise with peers across the country.

Due to the compressed timeline for ARPA HCBS spending plan development and implementation, states were more focused on identifying new and creative ways to improve and expand access to HCBS than on whether, how, and when to evaluate the impact of these new and creative undertakings. For most, evaluation became an undertaking that needed to be both planned and operationalized during the actual implementation of their ARPA HCBS initiatives. States that have started evaluation activities provide critical insights about why they found evaluation necessary and how evaluations are being conducted, and, most importantly, offer helpful recommendations for other states that have not yet begun evaluating the impact of this critical HCBS investment. These same states also offer ideas about how to maximize the impacts of future investments in our nation's LTSS delivery system.

State leaders are faced with enormous challenges at this critical juncture in long-term services and supports (LTSS) across the country. As our Collective continues to support states in their efforts to improve LTSS for older adults and people with disabilities, we hope the lessons learned from this research will provide practical information about how states can evaluate the impacts, success, efficiencies, lessons learned, and best practices of their ARPA HCBS initiatives. We also hope it will help to shape future investments in our nation's LTSS delivery system.

Martha A Roherty

Martha Roherty, Executive Director
ADvancing States

Introduction

The American Rescue Plan Act of 2021 (ARPA), which addressed a range of COVID-19-related challenges,[1] allocated over $37 billion[2] to "enhance, expand or strengthen" Medicaid-financed Home and Community based Services (HCBS). This is the most immense, one-time investment in HCBS to date. Structured as enhanced federal funding[3] for one year to be expended over the duration of the effort, the opportunity was too good for any state to pass up. The one-time, time-limited investment was implemented rapidly, primarily in response to the public health emergency.

Thus, states had limited time to brainstorm HCBS initiatives they could propose and undertake in the less than three years they would have to develop and operationalize. Due to the rush to apply for this enhanced funding, many have had to revise ARPA plans or, even scrap entire initiatives, during the ARPA implementation period.

As states hurried to identify new and creative ways to improve and expand access to HCBS for purposes of their ARPA HCBS spending plan proposals to the Centers for Medicare & Medicaid Services (CMS), many were not focused on whether, how, and when to evaluate the impact of these new and creative undertakings. While some have since developed plans for evaluation or modified their ARPA HCBS spending plans to set aside funds to support their assessments, evaluation of the massive ARPA investment in HCBS has been somewhat of an afterthought. Probably for a variety of reasons, neither the Act itself nor the CMS requirements for states' ARPA HCBS spending plans addressed evaluation activities. Of note, while the Act itself does

> The American Rescue Plan Act of 2021 (ARPA), which addressed a range of COVID-19-related challenges,[1] allocated over $37 billion[2] to "enhance, expand or strengthen" Medicaid- inanced Home and Community based Services (HCBS).

---

[1] https://crsreports.congress.gov/product/pdf/R/R46777

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

[3] Enhanced federal funding was provided in the form of a 10% increase in states' Federal Medical Assistance Percentage (FMAP), otherwise referred to as an enhanced federal match. As described by CMS at https://www.medicaid.gov/medicaid/financial-management/index.html, "The Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP). States must ensure they can fund their share of Medicaid expenditures for the care and services available under their state plan."

not address sustainability of ARPA-related HCBS investments, largely because it was perceived by lawmakers as a response to the public health emergency, CMS's guidance to states does. It indicates that funds can be spent on both short-term undertakings in response to the public health emergency as well as sustainable long-term activities, and it asks states to describe how they would sustain their initiatives after the end of the ARPA spending period.[4]

With such a massive investment in our nation's largest HCBS delivery systems, we recognized the importance of learning which of the states' investments worked; that is, which resulted in the desired outcomes and which did not. Armed with such information, our state and national leaders will be better informed to establish future policies and make future investments related to Medicaid HCBS. Furthermore, with 12 months remaining in the ARPA spending period, states still have some time left to design and conduct evaluations of their initiatives so could benefit from learning about evaluation approaches used by some of the leading states. It is in this vein that we have developed this white paper to inform states in the near term and to help shape future policies and investments in the long term.

---

4   https://www.medicaid.gov/sites/default/files/2022-03/smd21003-update.pdf

I.   Methodology

To learn about states' experiences with and approaches to evaluating their ARPA spending plan initiatives, we surveyed all states about their evaluation activities in February 2023. Twenty-four states responded to this survey. We invited states that disclosed in the survey that that they were undertaking—or planned to undertake—ARPA evaluation activities to participate in one of three focus groups. In Spring 2023, we conducted three focus groups with a total of 14 individuals who represented 9 states. These individuals served in key leadership and advisory roles in each state's ARPA HCBS implementation. The information we gathered from the survey and during our focus groups forms the basis of many of the trends and analyses we present in this paper. This paper is also informed by our work supporting states with their ARPA initiative planning, implementation, and evaluation activities[5] and by our observations and analysis of state and federal ARPA HCBS activities. With any publicly available information from CMS several years away, this report gives a critical real-time assessment of the successes and challenges that states are encountering in spending ARPA funds.

> **With any publicly available information from CMS several years away, this report gives a critical real-time assessment of the successes and challenges that states are encountering in spending ARPA funds.**

This paper looks at the evaluation work undertaken or planned by states related to their ARPA initiatives and investments. First, it outlines the background of the ARPA HCBS endeavor, including CMS requirements and timeframes and a partial description of some of the creative uses states have found for ARPA dollars. Then, it describes the value and importance of evaluating innovations, pilots, and untested initiatives. Next, it details some of the evaluation efforts undertaken by some of the states that participated in our focus groups. Finally, it makes observations and recommendations about evaluation of ARPA initiatives for states that have started and for states that have yet to plan for evaluation—and it considers how evaluation could be addressed in similar undertakings in the future.

---

[5]   Recognizing that states needed to move quickly to take full advantage of this huge infusion of new federal dollars, six foundations—Arnold Ventures, the Care for all with Respect and Equity (CARE) Fund, The John A. Hartford Foundation, The Milbank Memorial Fund, the Peterson Center on Healthcare, and The SCAN Foundation—together provided support to the ARPA HCBS Technical Assistance Collective, a small group of non-profit organizations and independent consultants with extensive expertise in HCBS to support states in the implementation of the ARPA initiative.

II. Background on ARPA HCBS

Americans' average life expectancy has been increasing, and more Americans are living, and are living longer, with physical, intellectual and developmental disabilities, as well as dementia and other conditions. Consequently, Americans increasingly rely upon Medicaid, our nation's primary payor of long-term services and supports (LTSS).[6] Through Medicaid, states have long been required to cover facility-based LTSS or, otherwise stated, LTSS provided in 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.[7] 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.[8] Today, approximately 63% of total state Medicaid LTSS expenditures are for HCBS.[9]

While much has been accomplished to expand and strengthen our HCBS delivery systems during the last several decades, it is not enough. Many more older adults and people with physical disabilities could be served in HCBS settings rather than nursing facilities. For adults with developmental or intellectual disabilities, 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.[10] 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 and resulted in a variety of proposals to make sustained investments in our nation's HCBS delivery systems. While these proposals did not pass into law before the public health

---

[6] IF10343 (congress.gov)

[7] https://www.aarp.org/pri/topics/livable-communities/housing/2021-home-community-preferences.html

[8] HCBS Innovation During COVID: Payers & Providers (acl.gov)

[9] www.medicaid.gov/sites/default/files/2023-10/ltssexpenditures2020.pdf

[10] https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/

emergency, 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, which was projected to result in over $25 billion of total spending to expand services and infrastructure for Medicaid-financed HCBS. Current CMS projections place total ARPA spending at $37 billion.[11] The purpose of these funds was to enable states to directly improve access to HCBS and, coupled with the flexibilities permitted under the PHE, to ignite innovation in HCBS service delivery.

In spring of 2021, states were given approximately 10 weeks (extended from the original 30-day timeframe) to develop proposed ARPA HCBS spending plans to submit to CMS. We observed first-hand as many states furiously grabbed 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.[12]

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
Total	**922**

_____

[11] www.medicaid.gov/media/132286

[12] Derived from ADvancing States' Updated Analysis of State HCBS Spending Plans (ADvancing States Releases Updated Analysis of State HCBS Spending Plans | advancingstates.org). In this summary, some initiatives may have been counted more than once; for example, if a provider workforce and training initiative involved both a provider registry and a bonus payment for recruitment and retention, the initiative was counted more than once in the ADvancing States summary.

The ARPA funding opportunity was viewed by states as too big of an opportunity to forgo; every state and territory elected to pursue the enhanced funding. However, the compressed timelines presented a significant challenge to most states' administrative and program design capacities. They had limited time and resources to be thorough and contemplative in developing their spending plans and to efficiently expand HCBS services, populations, and infrastructures. Because states were required to identify and begin implementation of their chosen ARPA HCBS initiatives so rapidly, many ARPA HCBS spending plans include initiatives in areas the states had not yet fully researched.
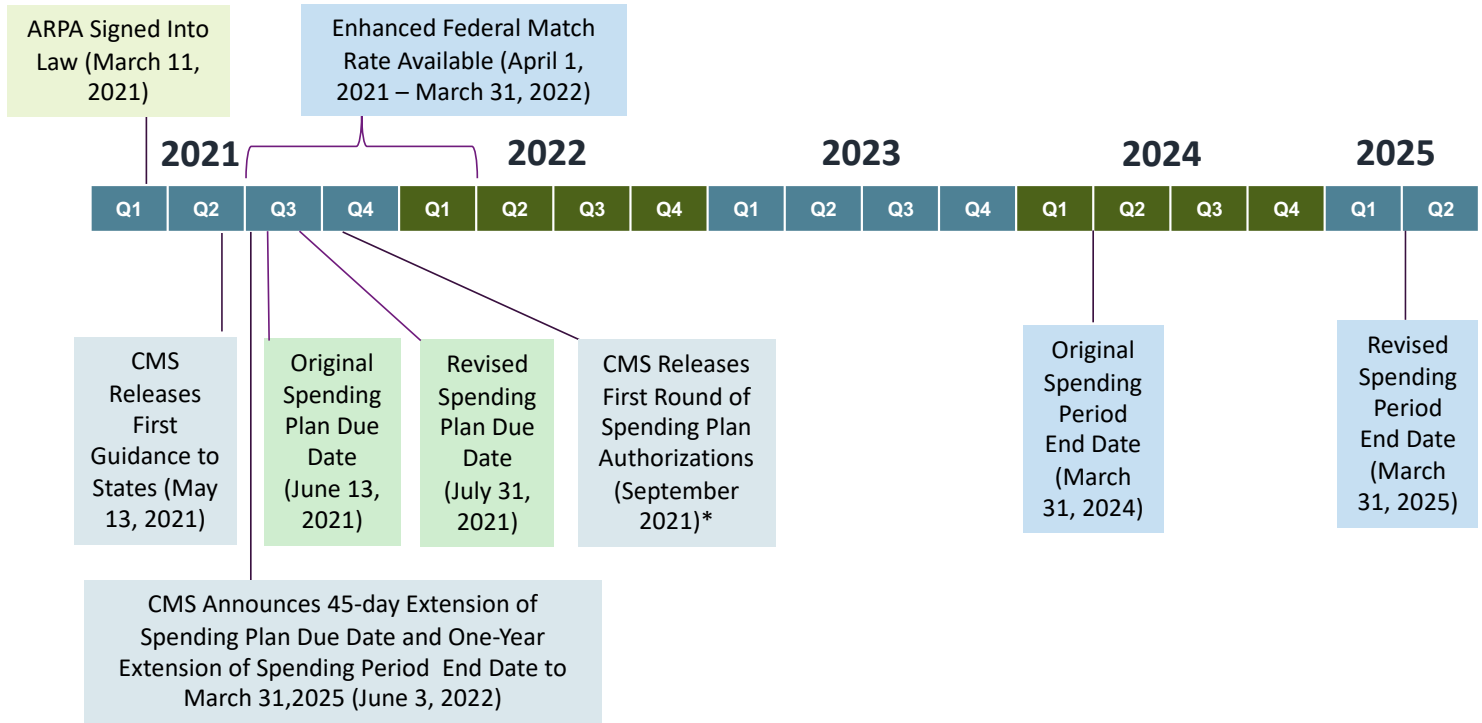
State ARPA HCBS initiatives are expansive, covering workforce, enabling technology, expansion of eligibility, quality systems improvements, case management and critical incident management systems investments, caregiver supports, housing pilots, and more. A more extensive summary of ARPA HCBS Initiatives can be found here. These far-reaching initiatives include some of the most creative and innovative investments in 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. If we are able to understand impacts of these investments, our learnings could offer insights about where and how future investments can be most impactful.

As we described above, in their rush to identify potential initiatives to propose to CMS and to respond to the public health emergency, most states were not thinking about evaluation. Nor were Congress or CMS. Overall, the statutory and regulatory agency requirements for ARPA HCBS spending plans were minimal. States were obligated to create new initiatives, comply with a maintenance of effort requirement, submit quarterly progress and spending reports, and spend all the dollars for their approved initiatives by March 31, 2024 (although states may now extend this deadline to March 31, 2025). States were not required to have fully formed, executable plans for implementing their ARPA HCBS spending plan initiatives. Nor were they required to undertake any steps to evaluate the efficacy or impact of their initiatives on achieving the goals of improving and expanding access to HCBS. The timeline for proposing, designing, and implementing their ARPA HCBS initiatives, which is extremely 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

ARPA Signed Into Law (March 11, 2021)

Enhanced Federal Match Rate Available (April 1, 2021 – March 31, 2022)

2021				2022				2023				2024				2025	
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2

CMS Releases First Guidance to States (May 13, 2021)

Original Spending Plan Due Date (June 13, 2021)

Revised Spending Plan Due Date (July 31, 2021)

CMS Releases First Round of Spending Plan Authorizations (September 2021)*

Original Spending Period End Date (March 31, 2024)

Revised Spending Period End Date (March 31, 2025)

CMS Announces 45-day Extension of Spending Plan Due Date and One-Year Extension of Spending Period End Date to March 31,2025 (June 3, 2022)

Note: Subsequent authorizations were issued piecemeal, and timing of authorizations in relation to submission date was generally not predictable.

III. The Importance and Value of Evaluation and the Purposes for Which Evaluation is Needed

I t is critically important to evaluate new initiatives. Through evaluation, decision makers can understand what worked as intended and what did not. The information gleaned can be used to improve upon initiative design, to shape future policies and investments, and to build public support for those policies and investments.

The Purpose of Evaluation. A single evaluation can serve multiple purposes and might be consumed by multiple audiences within a state. Some states want to incorporate concepts they tested into their 1915(i), 1915(c), or 1115 authorities. Doing so will require states to demonstrate to CMS the impact, efficacy, and value of what they want to do. Some states need to show their legislatures that new allocations of funds to sustain initiatives will be well-spent, will produce a positive return on investment, or will achieve other savings. In order to continue their initiatives beyond the ARPA spending period, some states need to demonstrate that the success of their ARPA HCBS initiative supports a legislative or regulatory change, a funding allocation, or other legislative action. Some states may simply need to report to their legislatures or communities about how the one-time investments were spent and what impact they had. Finally, some may just want to show to a variety of audiences that they were entrusted to try something innovative and that they were successful at creating, implementing, and operationalizing that something.

Figure 3 on page 12 helps to illustrate the varied purposes states' evaluations could serve.

Figure 3. How States Will Use Their Evaluation Results: Some Examples

Determine Whether to Sustain the Initiative

- To ascertain whether the initiatives were effective in achieving their goals and objectives, including whether each initiative met the state's metric of success, whether internal and external stakeholders perceived it as effective, whether funds were efficiently spent, etc.

- To give states interim data so they can retool initiatives to better achieve desired results by the end of the spending period.

- To decide whether initiatives should be continued, including whether an initiative should be modified through program refinements or continued as it was originally structured.

Support Legislative Request

- To make the case with state legislatures for sustainable state funding to continue the initiative.

- To demonstrate impact of initiative to legislators to support requests for legislative authority to sustain the initiative.

Support Request for Federal Authority

- To demonstrate cost-effectiveness as states pursue federal authority to incorporate initiatives or components of initiatives into new or existing HCBS authorities.

Confirm Initiative Executed as Intended

- Conduct audits to assure incentive dollars were spent on intended investments.

Advance State's Existing Strategic Plan

- Confirm or disprove need for investing in initiatives outlined in state's Multisector Plan for Aging and/or other state strategic plan.

Understand Impacts on Various Communities and Systems

- To reveal differential impacts on local communities so can reevaluate existing expenditures to better serve communities.

- To evaluate whether initiatives have an impact beyond Medicaid (e.g., justice, housing, etc.)

Defining Success. Accomplishing these aims is supported by meaningful evaluation that shows what the initiatives accomplished, who was impacted, how they were impacted, the outcomes, and whether these results reflect success as the state has defined it. Defining, in advance, what success means for each initiative helps a state evaluate how well the initiative measured up to the specific intended, expected, and desired outcomes.

While states might have had rough ideas of what success would mean for each given initiative, not all states expressly defined success upfront. Colorado, however, took very deliberate steps to define what success means, with definitions of success that differ by initiative as well as some metrics that cross multiple projects around key areas of interest (for example, a metric that is tracking, across all grant programs, the proportion of grantees that fall into a diversity classification category). Colorado adopted a "theory of change" approach for every initiative within which the state articulated in writing what success would mean for that given initiative.

Many states are finding that, in order to achieve sustainability of their initiatives, they need compelling evaluation findings to justify the investment of state dollars beyond the ARPA spending period. Most frequently, those findings seem to be considered in terms of the savings generated by the initiative. However, several states noted the importance of recognizing that the success of an initiative and value of sustainability may not be measured simply via a cost-benefit analysis. An initiative, they observed, could have been extremely helpful in increasing access to HCBS but may have required, for example, the hiring of new staff to operate, making it a successful initiative and a worthwhile expenditure because of the positive outcome. **Figure 4** highlights ways states are defining success.

Figure 4. States' Definitions of Success Extend Beyond Achievement of Financial Savings: Some Examples

We **have capacity** to conduct future evaluations of workforce and social isolation	**People served are better off** as a result of an initiative	Case management staff caseload and **workload is more manageable**
Culture change is achieved; providers are more willing to innovate with technology	Participants have **increased access** to HCBS services and **disparities are reduced**	We have **generated savings**; the initiative has a positive Return on Investment (ROI)
Recruitment and retention of direct care workforce has improved	We and our stakeholders have learned that the **initiative didn't have the desired impact**; we can now invest in other areas	Our **providers have increased their capacity** to comply with reporting requirements (e.g., EVV)

IV. What States Are Doing and What They Have Found So Far

There is much to learn from the approaches states have taken to design and conduct their evaluations, and the challenges they have faced in doing so. To date, there is little to learn about the impacts of the initiatives themselves. This is due in large part to the timing of the ARPA spending period. Below we highlight some of the most salient takeaways from the focus group states, gathered in the spring of 2023, approximately two years prior to the end of the ARPA spending period.[13] The experience of these focus group states is likely not representative of all states, since these states were generally selected based on their survey responses indicating that they had progressed further with evaluation planning and conduct than many other states.

To What Degree Are States Conducting Evaluations of Their ARPA HCBS Initiatives?
It appears that all states will conduct evaluations of at least some of their initiatives, but only some states will evaluate all of their ARPA initiatives. Those focus group states that plan to evaluate all their initiatives had a smaller number of initiatives, typically less than 10.

How Rigorous Are States' Evaluations? The degree of sophistication of states' evaluations ranges, even within a single state. For the most robust evaluations, states are engaging independent, third-party evaluators to conduct formal evaluations. All focus group states that conducted pilots described performing formal evaluations of these pilots, often conducted by an independent third party, so they could show the outcomes and determine whether they would want to implement the pilot in the long term. Generally, states are using other evaluation approaches, often leveraging available evidence and relying upon methods akin to those they use for routine policy and program analysis.

In some cases, states have been hampered by a lack of baseline data, particularly, as we describe below, with regard to the experiences and needs of participants,[14] their families, direct care workers[15] (DCWs) and small HCBS providers. In such cases, states

---

13 Some states, including some focus group states, have elected to end their ARPA spending periods prior to the Federal deadline of March 31, 2025.

14 The term "participants" is used to describe individuals who participate in HCBS waiver programs.

15 For the purposes of this paper, the term "direct care worker" is used interchangeably with the terms "direct service worker", "direct support professional" and "direct support provider", among other terms.

face constraints in study design, with no ability to employ a pre- and post-initiative comparison. Sometimes the impact of the initiative is difficult to measure, or the impact is expected to be felt in the long term and not during the ARPA spending period. For example, one state distributed funds to providers with the intent of strengthening providers and increasing the likelihood that their businesses will be more sustainable. After the first round of grant awards, the state realized the challenges with measurement when using this definition of success, so for the second round, the state modified its grant award criteria to simplify the audit and evaluation processes.

Grant programs fueled innovation at the provider and community levels. Some states asked grantees to conduct their own evaluations of the impact of their grant. Other states are attempting to evaluate the statewide impact themselves or are having a contractor or other independent evaluator conduct the evaluations.

> **There is much to learn from the approaches states have taken to design and conduct their evaluations, and the challenges they have faced in doing so.**

To What Degree Are Evaluations Being Conducted by State Staff Versus Other Parties? For more formal evaluations conducted by an independent entity, several states described a collaborative, iterative design process with a contractor or public university. All focus group states also relied upon state staff to design an evidence-informed evaluation of one or more initiatives. In Colorado, metrics are associated with every initiative, and the state will use these for evaluations. Most states employed more than one of the following staffing approaches to conduct their evaluations:

- Contracted with independent evaluators, an approach used widely by focus group states for pilot program evaluations

- Modified an existing consultant contract to incorporate independent evaluation of selected initiative(s)

- Established an intergovernmental agreement with a public university, as an expeditious alternative to undertaking a procurement

- Relied upon state staff, an approach typically used for less formal or robust evaluations

- Used ARPA funds to hire temporary state staff or independent contractors to perform various ARPA initiative roles, including evaluation roles

- Delegated implementation responsibilities to contracted Medicaid health plans, which can be nimble since they are not constrained by the same regulatory and procurement rules as state agencies

When Will States Conduct Their Evaluations and Have Results? With very few exceptions, the focus group states explained that they did not have results and did not expect to have them anytime soon. Some states have begun to see results of some planned evaluations. Notably, these states tended to have the ability to accelerate some aspect of their implementation work through streamlined procurement, continuation and expansion of an initiative that was already underway, or adopting initiatives that were already vetted through external workgroups. The acceleration of the implementation work created some time on the back end for evaluation. Some other states have received anecdotal feedback (e.g., comments or complaints from DCWs regarding workforce

initiatives) that has helped them to shape their evaluation methodology. However, most states described that they are or plan to be simultaneously implementing and evaluating their initiatives—and this is true even in the case of more sophisticated evaluations of pilots. In many cases, initiatives are operating for a very short period of time, sometimes as little as three to six months, so the evaluations are based on limited experience and may not capture sufficient data to inform decision-making. In these cases, states may need to employ an iterative approach to evaluation, examining interim results and, if they can sustain the initiative long enough, examining results after the initiative has been operating for a longer period of time.

Missouri had a rate study already complete and a rate increase in the works, so, rather than using the spending period for planning and analysis, the state was able to move very quickly to deploy ARPA HCBS dollars to help fund a rate increase. Other states, in contrast, found themselves having to conduct a rate study, a process that can take six to 18 months, leaving less time for implementation and evaluation. States that had a rate study, multi-sector plan on aging, or strategic plan in hand were better positioned to have initiatives operating for longer, generating more data that could be used to generate more conclusive evaluation findings.

Most states plan to complete their evaluations by the end of their spending periods—this does not necessarily allow them time to take the steps necessary to assure continuity or sustainability. For example, most states will not have results in time for legislative and budget cycles so will not be positioned to assure continuity. Some states will have results in time for legislative and budget cycles; however, they will not have time to conduct much stakeholder engagement and might encounter budget shortfalls, so their ability to impact the upcoming budget cycle or legislative session may be limited. We will expand upon these and other timing challenges in the next section.

In some cases, states' designed initiatives that are setting them up for future success in evaluation. For example, they are designing and building new information systems, automating manual processes, collecting baseline data, or developing and imposing new reporting requirements. Evaluation of these initiatives themselves was generally not contemplated by the states, but evaluation will be an intentional outgrowth of the ARPA investments.

What Have States Learned So Far From Their Evaluations? Before conducting state focus groups, we anticipated being able to present in this paper what states found from their evaluations. However, instead of talking about what they learned from their evaluation findings, most states were prepared to talk only about what they found about the evaluation process itself. Our focus group states were those who self-identified as being interested in and having made progress with evaluation planning and conduct. In other words, these states represent one end of a spectrum—many other states had not made as much progress with their evaluations. Nevertheless, most of the focus group states did not expect results until much closer to the end of the spending period. It is reasonable to surmise that some states that have not yet progressed with evaluation planning will not

have results before the end of the spending period—and in some cases, states may not have evaluation results at all.

During the focus group discussions, only a few states said they had results, and these were generally preliminary and for a subset of their initiatives. The findings the states shared include:

- Learning from one state via a DCW survey that DCWs are not concerned about just money—they also want support, a feeling of belonging, and the right training.

- Early data from one state's workforce survey revealed that some DCWs have not been receiving minimum wage.

- Results from one state found that ARPA funding achieved the desired impact of enabling the opening of additional Program of All-Inclusive Care for the Elderly (PACE) centers.

Interestingly, most of these early findings relate to the direct care workforce initiatives, an area for which approximately 40 states proposed at least one initiative. The fact that states' ARPA initiatives involved developing and conducting DCW surveys and censuses echoes the challenge we note elsewhere in this paper: that in many regards, states designed their ARPA initiatives without having a baseline understanding of stakeholders' experiences and needs.

In some cases, states are not expecting to have findings; rather, they aim to establish an infrastructure and baseline data to enable future evaluations. Arizona's initiatives invested heavily to do this for workforce development and social isolation.

How Did States Engage with Community Members to Understand the Impact of Initiatives? As we note above, savings and Return on Investment (ROI) are not states' only measures of success. Nor is service utilization data. Many evaluations are multidimensional, and diverse input is an important component of evaluations. Some states, including some of our focus group participants, were fortunate to be able to rely upon existing channels or structures (e.g., Money Follows the Person (MFP) or Multisector Plan for Aging advisory groups) to gather feedback from various perspectives about how to design evaluations and to gather data about the impact of initiatives.

California saw the ARPA funding as an opportunity to advance initiatives that were included in its Master Plan for Aging but not yet funded. Support from community members and governor's office was already established and they are very interested in evaluation.

Similarly, **North Dakota** turned to its Money Follows the Person (MFP) workgroup's prior input and recommendations, which were developed through a deliberative engagement process. As a result, the state knew where and how to invest its ARPA funds.

Both states used other community engagement methods, in addition to relying upon existing groups, sometimes specific to a particular initiative.

While understanding everyone's experiences is important, it is not easy. As a nation, we are only beginning to see somewhat broad use of participant experience survey instruments. Development of survey instruments for unpaid caregivers and DCWs lags behind that for participants. In contrast, providers often have established channels to influence policies and budgets—although the voices of some HCBS provider types and smaller HCBS providers are frequently excluded. Furthermore, states range greatly in the degree and means by which they engage community members. Some states have well-established community advisory councils, approaches to local engagement of community members, email "suggestion boxes" and routine use of public comment processes, and a variety of means to communicate bidirectionally with community members; other states do not. All these factors influence states' abilities to gauge the impact of their initiatives. Some focus group states noted the importance of balancing the providers' voices with the voices of participants, DCWs, family members and unpaid caregivers—and they saw ARPA initiative evaluations as an opportunity to strike this balance. States that have robust community engagement infrastructure described using it to gather input about the ARPA initiative evaluations.

Below we describe some ways that the focus group states sought to understand the experience of various community members.

- **Participants.** Many states are collecting and using participant feedback for their evaluations, largely via surveys. One state relied upon Centers for Independent Living to seek feedback directly from participants—a somewhat makeshift approach that will allow the state to gather participant input within their tight timeframes.

- **Family Members and Unpaid Caregivers.** States were less likely to gather feedback from unpaid caregivers, perhaps because channels and survey instruments for gathering this feedback are not as well established as for participants.

- **Direct Care Workers (DCWs).** Nationally, we have become increasingly conscious of the importance of DCWs contributions and lived experiences. One state recognized that it doesn't often hear directly from DCWs so is working with a vendor to figure out how to gather their input and how to incentivize paid caregivers to provide them with this input. One state's health plans hired a third party to survey DCWs. Another state is beginning to receive data from its workforce survey and has contracted with its consultants to identify lessons learned. It is hoping to conduct a second workforce survey so that it can have two years of data, and preliminary findings from the first survey are already informing its decision making. Another state posted notices for DCWs on the electronic visit verification (EVV) system to educate them about incentive payments available under an ARPA initiative. In response, some workers then called the state with feedback about what works and doesn't work. This was the first time the state has heard from DCWs and it is using this unanticipated informal input and anecdotes to inform their audit processes. In another case, a state received preliminary (and surprising) DCW input expressing opinions that retention bonuses are not a good idea; the state is now awaiting evaluation results to understand the impact of the retention bonuses.

- **Providers.** States typically have in place formal channels through which they can gather provider input, and provider associations can amplify messaging and advocacy reflecting provider experiences and desires. Several focus group states explained that, while they usually hear from larger providers, they want to hear from smaller providers, especially since so many HCBS providers are small, serve participants who live in rural and underserved areas, and are less likely to participate in state associations or have lobbyists. In other words, states need these providers and can't afford not to consider their perspectives. One state looked at this as a chance to hear from a different mix of providers. At least one focus group state required participation in a provider survey for all providers who received ARPA funds.
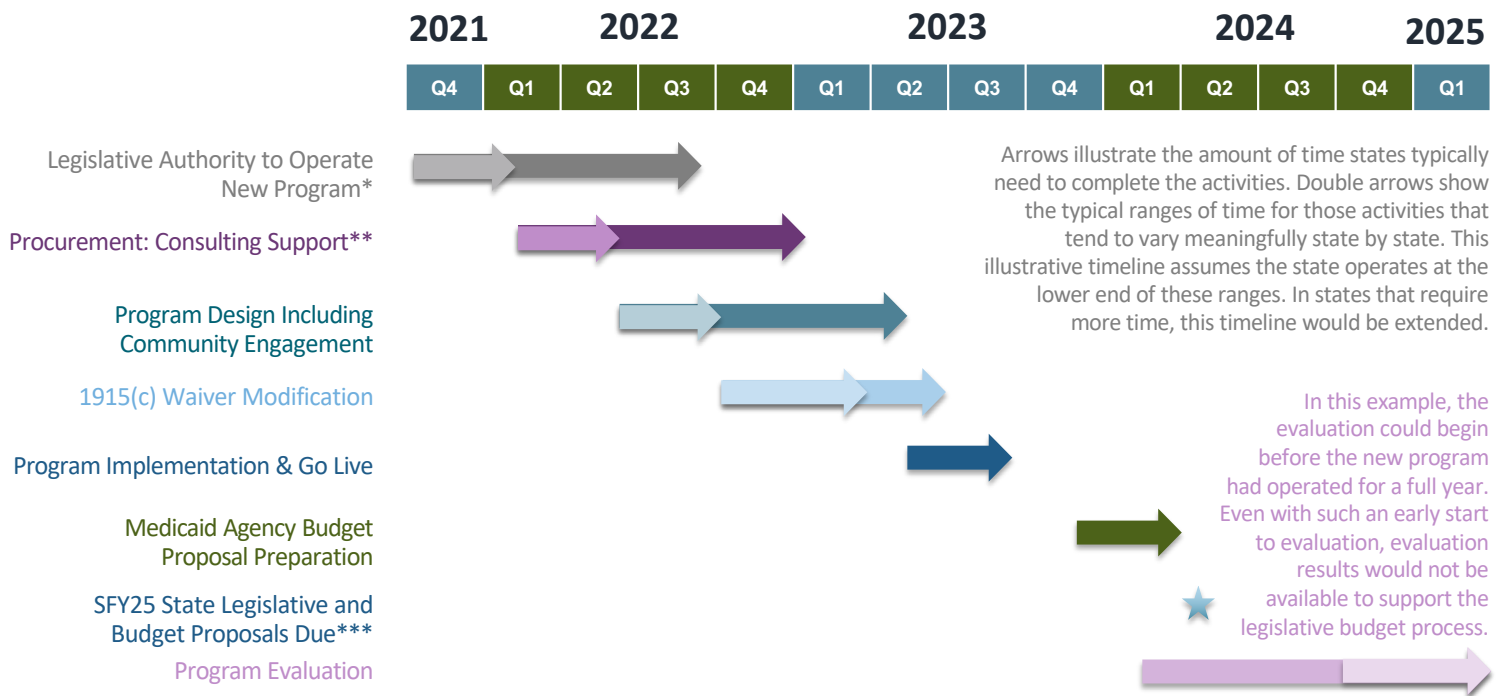
V. Key Challenges States Encountered

Without fail, every focus group state called out the many challenges introduced by the timing of the federal approval process and spending period. The compressed timeframe within which to create, plan, implement, complete, and evaluate their initiatives does not afford enough time, experience, and data for fully evaluating the efficacy of many initiatives. Additionally, it doesn't allow measurement of the after effect or lasting impact of any initiative. We provide a sample initiative project plan (see **Figure 5**) that illustrates the timing challenges states faced.

Many states are simultaneously implementing or operating and evaluating. Some states reported that their evaluation efforts might not be started or completed before the end of the ARPA HCBS spending period, or might be completed near the end of the spending period, hampering sustainability planning and seamless continuation of successful initiatives. Having the federally-defined end of the spending period fall in the middle of most states' fiscal years further aggravates this challenge: states that want to assure continuity of their initiatives are forced to begin the state budgeting and legislative process a good 18 months or more before the end of the spending period. Most of our focus group states expressed a strong desire for a longer planning period and the ability to spend ARPA dollars on evaluation activities after the end of the spending period.

Sometimes because of timing and sometimes because they face other challenges, states encountered obstacles when evaluating their ARPA HCBS spending plan initiatives. Some of the other key challenges are noted below.

1. **Evaluation Planning.** Under pressure to develop their spending plans in just 30–60 days and then to initiate implementation in short order after receiving federal approval, many states did not plan for evaluation at the outset, or planned for evaluation of only a subset of their initiatives. Those who did plan had little time to be thoughtful and strategic about evaluation. So, many states found themselves well into the spending period without a written plan, a timeline, a scope, or an evaluator considered for their initiative evaluations.

Figure 5. A Sample State Initiative Project Plan

	2021	2022			2023				2024				2025
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1

Legislative Authority to Operate New Program*

Procurement: Consulting Support**

Program Design Including Community Engagement

1915(c) Waiver Modification

Program Implementation & Go Live

Medicaid Agency Budget Proposal Preparation

SFY25 State Legislative and Budget Proposals Due**

Program Evaluation

Arrows illustrate the amount of time states typically need to complete the activities. Double arrows show the typical ranges of time for those activities that tend to vary meaningfully state by state. This illustrative timeline assumes the state operates at the lower end of these ranges. In states that require more time, this timeline would be extended.

In this example, the evaluation could begin before the new program had operated for a full year. Even with such an early start to evaluation, evaluation results would not be available to support the legislative budget process.

Some states could not begin implementation until they received legislative approvals. States that did not require legislative authority could skip this step. Occasionally, this process required more than a year.

**Procurement of information technology contracts is typically lengthier (e.g., 1-2 years), and implementation of new information systems is typically a multi-year process.*

***State funding needed for state fiscal year 2025 since ARPA spending period ends March 31, 2025 and SFY ends June 30, 2025. Budget process may begin earlier in states with biennial budget cycles.*

2. **One-Time/Time-Limited Nature of Funds.** Many states encountered or anticipated encountering state legislatures that were reticent to authorize potentially long-term initiatives that have time-limited funding, such as provider rate increases or eligibility expansions. Other states saw legislatures repurpose their ARPA spending, replacing a planned initiative with a new one. In both situations, states spent more time with legislative engagement and had less time to implement and operate their programs and, in turn, less data and time with which to evaluate. One state described that, because the funds are time-limited, the various initiatives tend to end at approximately the same time and will be competing with one another for evaluation staffing resources and, in turn, for state funding and legislative support. Furthermore, because all funds must be spent by the end of the spending period, no funds are available to conduct evaluation after the end of the spending period.

3. **Cross-Agency Coordination.** Establishment of new relationships, data sharing agreements and understanding of non-Medicaid programs was necessary for many states and viewed as valuable, but it took time and delayed implementation of initiatives.

4. **Data.** Some states noted that having sufficient baseline data is a challenge while others noted that having adequate data collection processes or information technology systems is a challenge for their evaluation efforts. Some states were accessing new data sources, establishing new data analytics functions, or launching new surveys. Workforce data was noted as a gap by many states, as was data regarding the experiences and needs of caregivers, DCWs and subsets of HCBS providers.

5. **Organizational and Staff Capacity.** Some states faced challenges related to program staff not understanding the mechanics or the import of meaningful measurement of initiatives. All focus group states were overwhelmed as they attempted to assign staff to the various planning and implementation activities, and these staffing challenges often meant that states could not move their initiatives along as quickly as necessary or preferred.

6. **Calculating costs avoided, particularly non-Medicaid costs avoided.** Quantifying avoided costs proved complex and sometimes difficult for states, particularly when it involved consideration of costs related to housing, justice system involvement, etc.

7. **Evaluating impacts of innovation grants.** A major goal of some states was to encourage innovation through grant programs that allowed the grantees to implement creative initiatives. While states do expect to capture new ways of thinking, several of them found that allowing flexibility and innovation when awarding grants makes evaluation difficult; it is hard to know what to measure when each grantee might be implementing a different innovation and aiming to solve different problems.

Arizona defined approximately 30 desired outcomes, and grant applicants had to select one or more of those outcome measures that would apply to their grant. Grantees will be required to report on achievements for the measures they selected, and the first grant reports will be submitted in early 2024. This approach will help the state to evaluate the impact of the grants and also gave a lot of direction to the grantees.

Wyoming established a rubric for self-evaluation that all grantees must use. Evaluation results will be shared with interested parties.

8. **Isolating the impact of each initiative.** With so many initiatives running simultaneously, states are sometimes challenged to attribute particular outcomes to a single initiative. This is particularly challenging for workforce related initiatives, where states may have multiple workforce-related ARPA HCBS spending plan initiatives, as well as non-Medicaid initiatives undertaken by state departments of labor or education, for example.

9. **Interpretation of Maintenance of Effort (MOE) requirements.** Through their ARPA initiatives, some states sought to conduct much-needed rate studies, which are themselves an evaluation of sorts. Others sought to update their participant needs assessment and service planning processes to be more person centered and to rely upon validated tools—another activity that involves extensive evaluation. Other states sought to replace outdated HCBS services with services that are more person centered and increase participants' independence and community integration (e.g., replacing sheltered employment with integrated employment). However, MOE requirements posed an obstacle for many states when they learned of CMS's strict interpretation of MOE requirements, which, while well-intentioned, too often prevent states from enacting changes intended to enhance, strengthen, or expand access to HCBS. In these cases, states now are faced with explaining to stakeholders why the undesirable findings of their evaluations (e.g., rate studies, assessment tool studies) cannot be rectified during the ARPA spending period.

Without fail, every focus group state called out the many challenges introduced by the timing of the federal approval process and spending period.

VI. Focus Group States' Recommendations to States Just Embarking on Evaluation

Focus group states offered recommendations for states that have not yet started or made substantial progress with evaluating their initiatives. Among these were:

1. **Be thoughtful about the scope of the evaluation.** Ensuring that the evaluation will serve its intended purposes is critical. This also is a factor to ensure the dedication of sufficient resources and time to produce a high-quality report of findings. One state explained that it is good to be clear in the beginning about the scope, including a lot of thought about the inquiry and why it is important.

2. **Prioritize evaluation resources on those initiatives that will require evaluation.** Not all initiatives are created equal and will not warrant additional funding or authority to be sustainable.

3. **Be transparent in your process and with your results.** Make public, broadly disseminate, and provide regular updates that explain how you plan to evaluate, how the evaluation is going, what the evaluation is finding, and what the final results entail, regardless of whether the initiative achieved the desired results. This transparency will help to generate trust with external parties, can help to inform evaluation methods and findings, and can serve as the foundation for future policymaking.

4. **Set expectations that some spending plan projects might not generate desired results.** Failure is sometimes a natural result of innovation, and some of the initiatives are testing new ideas. In any case, lack of success does provide important lessons for future innovation.

5. **Understand your bandwidth and engage an expert evaluator if your bandwidth and/or expertise are insufficient.** Don't forego evaluation because you lack the expertise to conduct it yourself. Hire an expert for this important work.

6. **If you intend to engage an external evaluator, consider state universities or current contractors.** Leverage existing agreements that can be modified to limit the need for a competitive procurement, or anything that might cause further delays to evaluation activities.

7. **Maintain a strategic plan (e.g., Multisector Plan on Aging) or wish list that outlines what the state aims to achieve with its LTSS delivery system.** That list can then be used as a starting point for identifying and prioritizing potential initiatives and their desired outcomes. Hence, less time can be spent on planning and more on evaluation. In contrast to traditional strategic plans, Multisector Plans on Aging are meant to be dynamic documents that are continually refreshed and typically include a list of attainable ideas that can be formed into initiatives. They also can serve as a valuable and consistent compass to guide long-term investments as state governments transition from one administration to another. Turning to readily available, vetted lists like these can allow states to spend less time on brainstorming, exploration, and planning and more on evaluation.

8. **Build on work already underway.** Expand upon existing projects, such as rate studies, as a means to accelerate work and enhance the impact of the state's current efforts.

9. **Expedite procurements.** Wherever possible, seek procurement or contract exemptions that will permit your agency to issue sole source contracts or modify existing contracts so that the typically lengthy competitive procurement process will not be required to secure an evaluator. Do the same for other contractors needed to execute the initiatives, so that implementation of initiatives won't be delayed by protracted procurement processes and, in turn, more time can be available for performance measurement and evaluation.

10. **Make provider participation as administratively simple as possible while holding providers accountable:**

    a. **Leverage existing requirements for evaluation.** Cost reporting, for example, was already in place for one state that leveraged cost reporting requirements as part of its evaluation.

    b. **Require providers to participate in evaluations as a condition of participating in initiatives.** Several states used this approach coupled with authority to claw back funds from providers who fail to participate.

11. **Focus on HCBS participants.** One state felt the most important metric was whether people served were better off because of an initiative. It designed its evaluation with this primary consideration and selected outcomes and metrics that would help determine whether their initiatives advanced the goal of improving wellbeing and better serving HCBS participants.

12. **Get stakeholder input.** Include surveys, listening sessions, public comment periods, and other means for participants and other community members to help shape and provide feedback during your evaluation process. Wherever possible, leverage existing and trusted pathways for community engagement, like those outlined in the section above, and where those do not exist, build them.

13. **Design survey administration methods carefully.** Access and technology choices are really important to generating increased survey response rates. For example, one state recommends brief surveys that respondents can complete within a few minutes on their phones.

14. **For innovation grants:**

   a. **Establish a well-defined set of uses** for the grant funds, so that an evaluation can be designed for each defined use.

   b. **Establish a set of desired outcomes** and assure that each grantee's performance will be measured for one or more of those outcomes, either via self-report or an independent evaluation.

   c. **Establish a rubric** for grantees to use in self-evaluation.

   d. **Provide a lot of guidance to grantees** to support them as they conduct a self-evaluation.

VII. Recommendations for Future Funding Opportunities

The funding provided by ARPA was the single largest, one-time infusion of dollars into the HCBS system ever authorized. It was wholly unprecedented in size, scope, and potential impact. While we hope that the ARPA HCBS investment was a down-payment on the significant funding needs of the system, lessons were learned about how the investment was structured and implemented that can benefit other efforts, including ensuring that work is evaluated, that outcomes are valued, and that long-term sustainability of state-level HCBS innovation and creativity is fostered. Below we outline for policymakers and CMS administrators our key recommendations that will improve states' ability to evaluate the impacts of their future HCBS investments.

1. **Allow More Time for Initiative and Evaluation Planning, Require Evaluation, and Allow Extra Time for Evaluation Activities.** Focus group states self-identified as having interest in evaluating the efficacy and impact of their ARPA HCBS initiatives. Yet most acknowledge that in the rush to identify potential ARPA HCBS initiatives to propose in their spending plans, evaluation was not a forethought. With more time for planning, they could have considered evaluation when designing their initiatives, rather than trying to retrofit an evaluation onto an existing initiative. Focus group participants also believe it would have been helpful if CMS had required participating states to conduct evaluations. CMS could have indicated that states would be required to demonstrate the impact of their investments and could have worked with states after their spending plan approvals to develop evaluation plans that could be implemented at the end of or immediately following their ARPA HCBS spending periods. Knowing they would have to evaluate could have helped states be mindful at the outset of what information they would need to know at various junctures in order to complete a successful evaluation.

2. **Facilitate Learning Between States.** There were many missed opportunities for states to learn together and from one another during the ARPA HCBS undertaking. With sufficient time, states could have learned much from each other as they planned and implemented their evaluations. They could have shared examples of spending plan initiatives, measures of success, approaches to addressing disparities and other considerations in the design and implementation of their initiatives, and more. They could have agreed upon approaches to take, assumptions to make, and more, creating fertile ground for comparisons across similar initiatives. Focus group states indicate that any meaningful data from other states' completed evaluations could be impactful in their evaluation activities and sustainability decisions. California has created a Learning and Innovation Center that will identify leading practices and compile data and results from other states to inform their future innovations. Moving forward, CMS or another entity could serve as a clearinghouse about states' efforts, sharing tools, documents, resources, policy documents, evaluation plans, and evaluation findings.

3. **Consider Other Investments to Support States.** Consider creative approaches to invest ARPA dollars to support states. For example, provide support, advice and expertise to support states in areas where similar initiatives are being pursued by a large number of states, like HCBS workforce initiatives. ARPA funds could be used to establish a center of excellence on workforce issues to support and advise states in their design, implementation, and evaluation of workforce-related initiatives. This approach would enable states to circumvent procurement rules that, for many states, hampered their engagement of experts and supplements to state staff, particularly during planning and the initial months of the spending period. States could quickly gain expertise, learn about successful demonstrations in other sectors or other states, share information and tools through learning collaboratives, etc.

For areas being pursued by fewer, but still a good number of, states, ARPA funds could be used to establish clearinghouses to facilitate the sharing of initiative design and evaluation findings across states, to develop toolkits for states' reference as they design and implement their initiatives and evaluation plans, and to create other resources to help accelerate our nation's evaluation of what works to enhance, expand, or strengthen HCBS delivery systems.

Similarly, such a center of excellence could provide advice, support and expertise related to community engagement. For states that were constrained by lack of staff and consultant resources, perhaps state-specific technical assistance could be made available as has been done for other Medicaid initiatives. If expert consultants and/or supplements to state staff resources could be made available via a similar means, states could overcome some of the delays and other challenges resulting from limited staff resources and expertise and from lengthy and complex state procurement processes.

4. **Dedicate CMS Time and Resources to Support States.** The massive state-level infusion of dollars should have been coupled with a significant investment in CMS infrastructure and resources to support the implementation of the ARPA HCBS initiatives. CMS had limited time and resources to support states as they brainstormed what and how to implement. Additionally, there was consensus among our focus group states that CMS had insufficient staff time and resources to review, work with states, and get ARPA HCBS spending plans approved as expeditiously as the short ARPA implementation period really required. While ARPA HCBS spending plan approvals were expedited as much as possible given the constraints on staff time and resources, states lost some necessary time in the waiting. Additionally, the CMS staff approving ARPA HCBS spending plans were not the same staff from which states awaited approval of authorities necessary to implement some of their initiatives, nor were they staffing the expedited requests for amendments to waivers, etc. The time spent trying to obtain ARPA HCBS spending plan approvals and then plan and implement initiatives, focus group states indicated, cut into time that could have been spent operationalizing their initiatives, planning for evaluation, and evaluating results.

5. **Make Innovation Grants Unrestricted.** Among the challenges we discussed above were states' struggles to innovate within the confines of how the ARPA HCBS investment was structured as an federal funding increase tied to a Maintenance of Effort (MOE) requirement. As we note above, while well-intentioned, the MOE requirement often prevented states from making rational changes that promote person-centeredness, workforce development, and many other state and federal goals. Finding creative, impactful initiatives that could be tried and tested through meaningful evaluation within the timeframes of the ARPA HCBS program was challenging. Fear of running afoul of the MOE rules prompted many states to choose initiatives that were, by their nature, harder to evaluate—or where initiatives that benefited the vast majority had to be abandoned because of a potential negative impact on one or few. Many of the ARPA initiatives involved brand-new, untested ideas with no baseline data that could be leveraged in an evaluation. If the intention is innovation for purposes of increasing availability and access to HCBS, state focus group participants suggest it would have been better structured as an unrestricted innovation grant enabling the most creative problem-solving possible.

6. **Establish a (Non-PHE) Pathway for Expedited Federal Approvals.** The federal approval process of ARPA spending plan initiatives is, perhaps, one of the few things that benefited from the federal pandemic-related Public Health Emergency (PHE). Nearly every state relied upon Appendix K authorities to implement one or more of their initiatives. In the absence of a PHE, these expedited, more flexible waivers would not have been available to states—their initiative implementations would have been delayed by precious months, and substantially more of their limited staff resources would have had to be allocated to the waiver modification process and its rigorous cost-effectiveness demonstrations. Furthermore, without the flexibilities permitted under Appendix K authority, state innovation would be constrained. The ARPA spending plan experience has taught us that expedited approvals and enhanced flexibilities enable the nimbleness and creativity that is at the heart of innovation and allow states to allocate more staff resources to evaluation planning and execution.

VIII. Conclusion

Clearly, effective and timely evaluations will help us to get the most out of Congress' historic investment in our nation's HCBS system. Not a single focus group participant or expert with whom we have talked thinks evaluation of ARPA HCBS initiatives is ill-advised. Such evaluations can take many forms and can serve many purposes, whether simply to determine if an initiative was worthwhile, to establish best practices for moving forward, or to actually plan for sustainability.

The fact is that the ARPA spending plan initiatives—and states' decisions about what to do with them at the end of the spending period—simply do not seem very well substantiated without evaluation. Individual states and our nation's leaders collectively still have great opportunity to learn from this historic investment. States that have not yet planned or conducted evaluations can use the strategies we outline herein to conduct their evaluations. Perhaps most importantly, our nation's leaders have time to evaluate even after the ARPA spending period ends. These evaluations do not necessarily need to be conducted only by states. The private sector and federal government are particularly well-positioned to help us understand what strategies seemed to work, not to work, or to demonstrate some promise; they can examine results across many states and observe how small or large differences impacted outcomes. While we are not clear that all states have collected the data that would be necessary for a national evaluation of the impacts of those initiatives, a national examination of the current initiatives and the states' experiences would be useful. Identifying lessons learned and promising practices as well as creating a collective knowledge base could all help point our country toward HCBS system investments that stand a greater chance of having the desired results. Any learnings from evaluation results released after the end of the ARPA spending period are sure to have lasting influence on both state and federal decision making.

> **Clearly, effective and timely evaluations will help us to get the most out of Congress' historic investment in our nation's HCBS system.**

Our experience with ARPA to date also provides some important lessons learned that we hope will influence future federal investments in our nation's HCBS delivery system. Evaluation and sustainability are not feasible if the timing is wrong. It appears that for most ARPA initiatives, states will not have evaluation results in time to get the legislative and federal authority needed to continue their initiatives beyond the spending period.

So, in many cases, the initiatives will simply end—or there will be a gap when the initiative will not operate until the needed authorities and sustainable funding can be secured. Gaps like these cause unnecessary administrative burden for all involved and, more importantly, cause confusion and may threaten continuity of services for the very people the initiative aims to impact—HCBS participants.

The yeoman's task of evaluation design and execution should not have fallen solely to the states. Ideally a critical component of the authorizing legislation itself would have established resources to support the states and to serve as a clearinghouse, so that the learnings from these unprecedented investments could be readily shared across states and could have lasting influence by guiding deliberate investments in our nation's HCBS system rather than having a state-by-state impact that is often time-limited.

Despite these challenges and missed opportunities, there is still much to learn from the ARPA HCBS initiatives themselves and about how to structure future investments of federal and state dollars in our nation's HCBS delivery system. Additional investments in evaluation and information sharing will only serve to further the reach and sustainable impact of Congress' ARPA HCBS investments. In the near term, Congress' historic investment in HCBS under ARPA will help many states improve access to and delivery of services so that more individuals with disabilities, older adults, and others in need of LTSS can receive high quality services and supports in communities in the least restrictive settings possible.

Notes

ADVANCING STATES

Leadership, innovation, collaboration for state Aging and Disability agencies.

241 18th Street S, Suite 403
Arlington, VA 22202
Phone: 202-898-2578
www.advancingstates.org
www.hcbs.org