American Rescue Plan Act of 2021 (ARP) Section 9817: Overview of State Spending Plans

CMS is providing a high-level overview of the states’ planned activities based on spending plans reviewed by CMS

$2,606 Additional Spending per Beneficiary
On average, states plan to spend an additional $2,606 for home and community-based services (HCBS) per beneficiary on activities that enhance, expand, or strengthen HCBS.

CMS Has Approved All States' Spending Plans
All states can claim the 10 percentage point HCBS FMAP increase from April 1, 2021 to March 31, 2022.

Total of $25B in Planned Spending Across States
According to states’ spending plans submitted to CMS, each state plans to spend between $31.6 million and $4.63 billion in state and federal funds on activities that enhance, expand, or strengthen HCBS under Medicaid. These amounts will change as states further plan and implement their activities under ARP section 9817.

1 For some states, CMS has asked the state to provide additional information before one or more proposed activities to enhance, expand, or strengthen HCBS in the state’s spending plan and narrative can be approved, and/or has identified an activity that is not approvable under ARP section 9817. For all states, the approval to claim the FMAP increase is based upon the state’s continued compliance with program requirements as stated in State Medicaid Director Letter #21-003 - https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf
**1. Expanding Beneficiary Services**

States are expanding HCBS using various federal statutory authorities, such as section 1915(c) waivers, State Plan Amendments, or section 1115 demonstrations; implementing pilot programs; implementing efforts to reduce waitlists, increase access to services, and/or exploring new service models for individuals with complex conditions.

**States Proposing To Eliminate or Reduce Waiting Lists in HCBS**

Number of Additional HCBS Slots Proposed

<table>
<thead>
<tr>
<th>State</th>
<th>Proposed Slots</th>
</tr>
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<tbody>
<tr>
<td>California</td>
<td>7,000</td>
</tr>
<tr>
<td>Alabama</td>
<td>3,000</td>
</tr>
<tr>
<td>North Carolina</td>
<td>2,114</td>
</tr>
<tr>
<td>Tennessee</td>
<td>2,000</td>
</tr>
<tr>
<td>Texas</td>
<td>1,549</td>
</tr>
<tr>
<td>New Mexico</td>
<td>1,400</td>
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</tbody>
</table>

**Minnesota** proposes to create a new **Community First Services and Supports (CFSS)** program that expands the existing personal care benefit offered under section 1915(i) and 1915(k). This program will allow spouses and parents to become a support worker for their family members, allow goods to be purchased to aid independence, provide consultant services for person-centered planning, and allow direct service professionals (DSPs) to bill transportation time.

**State Highlights: Expanding Beneficiary Access to HCBS**

**Illinois section 1915(i) Implementation** for children under the age of 21 with intensive behavioral health needs. Funds would support providers’ program planning and service implementation activities, including training and onboarding of clinical staff, creating program policies and procedures, and establishing operational infrastructure and processes.

**Louisiana’s Children’s Medicaid Option (Act 421-CMO)** is a program that offers healthcare services to the population contemplated under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 97-248). This program will provide Medicaid benefits to children with disabilities who are under the age of 19, who are otherwise ineligible for such benefits because their household income exceeds state-established limits for Medicaid eligibility. With the additional funding made available through ARP section 9817, the state is able to allow for unlimited enrollment and open the program to all children who qualify.

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2 Only included data from states that specified additional HCBS slots in their spending plans. For Alabama, the proposed slot count is from the approved state’s waiver amendment that state mentioned in their spending plan (AL.0068.R07.06). North Carolina will need legislative approval for 1,114 slots and 1,000 slots will not require such approval.
2. Strengthening the Provider Workforce

States are providing one-time payments to provider agencies and/or direct service professionals (DSPs), establishing DSP training and certification programs, creating workforce registries (e.g., statewide list of credentialed DSPs) and web-based hiring platforms that enhance employment opportunities and/or allow beneficiaries who self-direct services to find workers.

- States are proposing $4.59B in total planned spending for rate increases/adjustments, $3.10B for retention payments and one-time bonuses, including scholarships, loan forgiveness and/or training completion bonuses, and $1.04B to improve DSP compensation by offering hourly wage increases and benefit packages.

State Highlights: Payments to Retain and Recruit DSPs

New Hampshire is requiring their managed care plans to pay uniform percentage increases on top of negotiated rates for specific procedure codes to qualifying providers. The uniform percentage increases differ from code to code based on the services provided and vulnerability within the marketplace. Providers must direct the payments to the workforce in the form of recruitment, retention, training and tuition reimbursement for relevant health care education, or career ladder development.

State Highlights: States’ Workforce Development Efforts For The Future

Kentucky plans to provide cross-training of Aging and Disability Resource Center, Community Mental Health Center, Medicaid Eligibility, and Adult Protective Services staff on LTSS topics to develop more experts.

California’s Dementia Aware program will implement annual cognitive health assessments to detect early signs of dementia and will develop a culturally competent dementia care training program. The continuing education in geriatrics/dementia training will be offered to all licensed healthcare providers.
3. Enhancing the Use of Technology and Telehealth

States are providing equipment to enable telehealth usage, expanding beneficiary access to assistive technology, and/or modernizing state Medicaid Management Information System (MMIS) / information technology (IT) infrastructure.

- **$1.6B** in total planned spending from **18 states** to expand or begin telehealth utilization and provide necessary equipment to potentially **2.9M** HCBS beneficiaries.
- **$516M** in total planned spending in **15 states** to improve MMIS/EHR/IT infrastructure to enhance service delivery to beneficiaries.

**State Highlights: Telehealth Pilots to Explore Payment Policies**

- **District of Columbia** proposes a pilot program to test strategies that may be used to develop a reimbursement policy for remote patient monitoring. This pilot grant program will cover the cost of using remote patient monitoring services for individuals with chronic conditions or HCBS beneficiaries, especially those at risk for adverse outcomes due to COVID-19.

**State Highlights: Investing in IT Structure and Using Data for Insights**

- **Connecticut** proposes to expand data used to identify critical incidents through a Critical Incident Management System Enhancements and Improvements initiative. Currently using Medicaid claims data, this initiative will add Medicare and level of need data as well as admission, discharge, and transfer information to the claims that are reviewed.

- **Georgia** plans to develop infrastructure to incorporate electronic health records (EHR) into the state’s existing systems and incentivize providers to adopt EHRs.

**76%** of the planned state spending related to enhancing use of technology and telehealth is related to expanding telehealth utilization and providing equipment to beneficiaries.
4. Improving Quality

States are adopting new quality measures, implementing beneficiary experience surveys, and/or exploring outcome-based payment initiatives.

- **11 states** plan to explore **outcome-based payment initiatives for HCBS** that will move the state to begin performance and quality-driven payment systems.
- **14 states** propose to review and update existing **quality measures**.

**State Highlights: Outcome-Based Payment Encouraging Workforce Development**

**Tennessee** proposes to **require their managed care plans to pay quality incentive payments to HCBS providers that will offset the first year costs of wage increases for frontline workers that complete a competency-based training program**. At each training milestone, providers would be expected to implement these wage incentives for frontline HCBS workers and may then seek a quality incentive payment to help offset the cost of these incentives during the first year. As a condition of receiving the quality incentive payment, the provider will agree to continue such incentives for the worker going forward and provide data to help evaluate the efficacy of the approach in increasing satisfaction and quality (for the person supported as well as the workforce) and in improving workforce recruitment and retention.
Most Commonly Proposed State Initiatives

5. Impacting Social Determinants of Health

States are improving employment opportunities, addressing homelessness, providing housing supports, and/or providing grants to innovative providers.

- **$266M** in total planned spending in **12 states** to **improve employment opportunities** for people with disabilities and older adults.

**State Highlights: Expand Pilot Incentive-based Payments for Supportive Employment Services**

**Colorado** plans to **expand a supported employment pilot** to determine if expanding incentive-based payments for supported employment services within the section 1915(c) waivers is cost effective and produces positive outcomes.

**State Highlights: Expand Outreach and Engagement with People Experiencing Homelessness**

**Washington State** proposes a **Homeless Outreach Stabilization Transition program** to expand outreach and engagement efforts to individuals with a substance use or co-occurring disorder to provide healthcare services and connect individuals to additional treatment and resources. Homeless outreach stabilization transition (HOST) teams consist of mental health, substance use disorder, and medical professionals who provide community-based medical and behavioral health treatment and stabilization services to **individuals who are experiencing homelessness**.

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**Notes:** Source of data is states' spending plans reviewed by CMS as of November 30, 2021, and CMS' internal analysis of Transformed Medicaid Statistical Information System (T-MSIS) beneficiary counts for FFY19. All spending plan information is reported by states and subject to change as states submit updated plans to CMS. Planned total spending amount and program category counts are subject to changes per states' quarterly spending plan updates. Planned spending and category counts are not mutually exclusive as states have programs and initiatives that fall into multiple categories. Information includes total planned spending, which may include both state portion as well as federal match portion. DE, NM, OH, PA, and WI spending plans did not separate the planned budget by initiative, therefore, total spending was evenly allocated to each initiative.