Community Engagement and Equity in ARPA HCBS Spending Plans: Key Informant Thematic Analysis

Executive Summary

Section 9816 of the American Rescue Plan Act (ARPA), signed into law in March of 2021, and the proceeding extension issued by the Center for Medicare and Medicaid Services (CMS) encourages state to include robust stakeholder engagement and good faith public notice in their spending plans for the billions in additional funding provided to states and local jurisdictions. While specific requirements remained loose, CMS emphasized engagement beyond facilities, plans, and providers. Specifically, states were encouraged to engage family members, caregivers, aging and disability networks, and the direct support workforce. The extension particularly emphasized the need to address barriers to care and the workforce crisis with home and community-based services. At the same time, states navigated significant and mounting barriers to making progress on equity and community engagement in their ARPA spending plans including aggressive timelines and a lack of infrastructure. However, robust examples of states finding creative and innovative approaches to bolster equity and engagement in home and community-based services still exist. These states represent a diversity of geography, political landscapes, and communities of HCBS beneficiaries. These state-specific examples provide other states realistic, pragmatic, and replicable policy roadmaps to using existing assets to enhance their own approaches to community engagement and equity.

Introduction

To understand the experiences of state policymakers in their HCBS spending through their ARPA allocated dollars, we spoke with a group of national key informants. These key informants have been involved in home and community-based services (HCBS) ARPA spending planning and implementation in various capacities, including advocacy and providing technical assistance to state policymakers. Key informants included national advocacy organizations, federal officials, academics, and private sector consultants. A total of eleven interviews were completed from November 2022-January 2023. The interview guide used is attached as Appendix A. These conversations offer a glimpse into the opportunities, barriers, and challenges states have encountered as they pursue HCBS improvements that are person-centered, equitable, and informed by the input of community members. Importantly, key informants were able to identify priority states that have taken innovative approaches to equity and community engagement, as well as states with the infrastructure and appetite to make improvements in these areas.

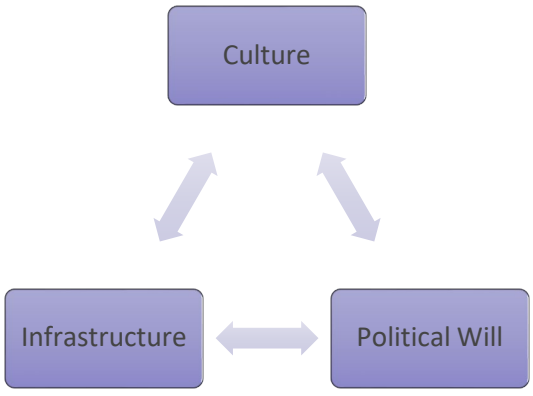
This analysis is organized thematically, concluding with a list of priority states identified by key informants. The goal of this analysis is to both highlight examples of innovative state approaches and identify the best opportunities for advocates to support states seeking to advance their community engagement and equity agendas.

I. Equity Key Themes

Equity within State ARPA Spending
Several themes emerged related to racial equity and health justice:

- All states have significant room to grow
- States with pre-existing equity initiatives were able to incorporate them into their ARPA spending plans
- The aggressive timeline hindered planning - some states creatively navigated this

Throughout all interviews, key informants agreed that each state has room to grow in how they approach racial equity and health justice. Considerations for what would be labeled as doing well or being particularly creative within ARPA spending plans were heavily dependent on the context, history, and unique challenges and strengths of each state. One framework for helping parse out these differences is viewing states in terms of culture, political will, and infrastructure. A culture of equity may lead to the political will to address inequities which may lead to the infrastructure needed to do so. In terms of stages of change, states vary greatly; some may be just developing a culture of equity, others developing the political will, and others the infrastructure. While this framework may be helpful, due to the dynamic nature of states it is also not exhaustive. States may be at various stages of development within each area, developing areas concurrently, and or move forward and backward in some areas simultaneously. The complex relationship between these factors may be best illustrated in the diagram below.



Additionally, some states have been doing equity work for a long time, others are doing equity work in certain areas, some are just beginning to consider the infrastructure needed to do equity work, and others have groups of people focused on equity but lack larger buy-in across the state. However, all states have room to grow regardless.

States Well Positioned for Equity: Due to the quick turnaround required for ARPA spending plans, states with pre-existing equity initiatives, concurrent projects with an equity focus, and/or equity specific infrastructure were at an advantage. Making meaningful investments towards equity with ARPA dollars was much easier if a framework was already in place. For example, California's Master Plan on Aging, a plan to build CA for all ages by 2030 via five goals and 23 strategies was already in formation and included equity initiatives tied both to HCBS and the workforce. Rhode Island's LTSS redesign, LTSS: No Wrong Door, was underway and brings together an inter-agency team to advance person-centered options counseling, conflict free case management, and modernize LTSS services with an equity lens. States such as Pennsylvania had already developed frameworks with equity initiatives on how to bolster the direct care workforce. Illinois had pre-existing initiatives and interest in permanently raising wages for the direct care workers. Similarly, other states had preexisting community engagement infrastructure with an equity focus. Indiana has been working closely with the Indiana Minority Health Coalition, Arizona has done work to engage tribal communities, and Colorado has created infrastructure to ensure equitable and transparent access to information. As will be discussed in more depth below, some states also had pre-existing plans to address the workforce crisis that they were able to build upon. In this sense, states that had already done the groundwork and engaged in change to create more equitable systems were posed to more easily leverage that infrastructure. These states are also often better positioned to make longer-term impacts given the multi-year focus of many pre-existing initiatives.

States with Appetites for Equity Work: As discussed above, indicators of an appetite for equity work showed up in cultural, political, and infrastructural change. Many key informants discussed states where there is a desire to engage in racial equity and health justice work, but a lack of larger buy-in, conducive culture, and/or political will. In many of these states, equity is not as explicitly addressed in spending plans and more general "all ships float with the rising tide" approaches were taken. Examples given by key informants were Mississippi, where state workers have an appetite for equity work but there is cultural and political pushback. Maryland was described to be in a similar situation. Kentucky is wanting to address inequities in their LTSS system but is getting pushback in using disparity and equity specific language in their contracts. Ohio was given as unique example, where generally there had been political pushback but their spending plan explicitly discussed equity. Other indicators of an appetite for equity discussed by key informants included states engaging communities typically left out of the decision-making process, such as the examples above, and states viewing workforce issues through an equity lens.

Notable Themes in State Approaches to Equity: During interviews key informants were asked about states thinking long-term, innovating, or engaging in equity work in specific areas. Again, key informants emphasized that context, both in terms of each state and the larger public health emergency, was key factor for whether ARPA spending plans could be considered innovative or not.

"...there's been a pivot in the degree to which ARPA funding is innovative. A lot of that is focused on this idea that we need to recover from COVID. There's been this incredible drain on state resources. ARPA funding was meant to be something that I'm not totally sure it is at this point or can be at this point. [...] People are like, 'We just need to survive.'"

Key informants discussed how some states were able to find ways to quickly mobilize ARPA dollars with longer-term equity goals in mind. Key informants also discussed trends in how states were focusing equity efforts in specific areas within their ARPA spending plans. The two areas that were mentioned most frequently by key informants were:

- Provider Supports and Workforce Issues
- Technological Infrastructure and Accessibility

Rapid Activities with Longer-Term Implications: Generally, states that came up in this area took the approach of quickly moving funding out into the community or to frontload an investment such as consultation or training. For example, New York, D.C., and Arizona hired consultants and/or created new positions to focus on equity. Other states such as Rhode Island and Vermont created rapid community grants, putting ARPA dollars into the hands of community organizations to address and explore equity issues on a more local level. States such as Illinois and Vermont are also using ARPA dollars to fund programs that require a frontloading of investment to get started such as developing workforce training.

Provider Supports and Workforce Issues: The direct care workforce came up in majority of the key informant interviews. State approaches to addressing equity issues within the workforce ranged from broad initiatives to targeting specific groups and issues. One key informant, referenced a report by New America which outlines how majority of states have given temporary wage increases using ARPA funds while twelve states are aiming to make increases permanent. However, as best said by another key informant, "wages are necessary but insufficient to address the pervasive problems with the workforce."

Overarching themes that emerged from key informants in how states are addressing workforce equity issues were:

- Establishing direct care workforce taskforces and/or advocacy/advisory groups
- Contributing to long-term planning to bolster the workforce
- Training and certifications to support competency, and professional growth and opportunity
- Addressing social issues that impact specific groups within the workforce

Key informants provided several examples of states creating taskforces or advisory groups. Ohio has created a cabinet level taskforce that is advising ARPA spending. California has the Center for Caregiver Advancement that has been able to influence ARPA spending. Rhode Island has developed the health Professional Equity Initiative which is chaired by the Lieutenant Governor and guided by their Equity Council. Maine is working with the Long-term Care Ombudsman Program to develop a workforce advocacy group. Arizona has created a direct service workers advisory group. New York City has created a workforce advocate position to monitor workforce issues and advocate for improvement, a model that may be viable to expand to the rest of the state. While all

these initiatives provide a voice and seat at the table for the workforce, they vary in how equity focused and robust they are.

"Almost every state has made investments in their workforce because it's so lynchpin to home and community-based service success at large. I think a number of states have tried to think about it with a lens around equity and the disparate universe of individuals who comprise the workforce and really thinking about some of those."

One key informant discussed how 16 states have created state-commissioned blueprints to addressing workforce issues. While these blueprints vary in terms of their focus on equity and engagement of the community, generally speaking states with these blueprints are thinking proactively and long-term in how to bolster and maintain their direct care workforces. Other examples, include California incorporating equity initiatives specific to the workforce as part of its Master Plan on Aging.

"This is the challenge, right, is that the states usually see the diversity of this workforce and they think that just supporting these jobs is an equity approach itself. And what we argue is that's partially true. But the other part is that there are actually explicit things you can do to address populations. And so, I don't think we've seen much progress in that regard yet. And so, there's a lot of room to grow."

Key Informants also discussed trainings and certifications that states are developing to support professional growth and employment opportunities. Wisconsin is creating universal worker certification which allows direct care workers to work across settings and share training and approaches. Rhode Island is focusing on diversifying the workforce by partnering with the state school to reach more underserved communities and communities of color. California is providing stipends to direct care workers that are directly tied to training. Unfortunately, in other states such as Georgia key informants discussed instances where one-time payments were approved but were not making it to the direct support workers due to a lack of awareness and proper implementation. In this particular instance, direct support workers also had not clear path to follow up on these payments if they were not received.

Other states are addressing social factors that impact specific groups within the workforce. Minnesota has been working to address transportation, childcare, tuition and other financial needs of direct care workers. Illinois has focused on supporting undocumented immigrants to join the direct care workforce by creating pathways to obtaining a driver's license using a foreign passport or birth certificate. States are also adopting non-discrimination protections for LGBTQ+ people that cover employment and public accommodations.

Technological Infrastructure and Accessibility: While not as frequently brought up as workforce issues, key informants did discuss how some states are making one-time investments in technological infrastructure including accessibility, systems improvement and increases IT/data

capability. Examples included states improving case management systems, intake eligibility systems, interfaces between data sets, and data transparency. Other states are using funding to ensure people who need technology to participate in daily activities receive it and that people's needs are properly matched to available staffing. These one-time investments contribute to the infrastructure needed to improve equity across service delivery systems.

Intersectional Approaches to Equity: Some key informants discussed the need to look at equity across ethnicity, language, LGBTQ+ status, and ability in addition to race. Minnesota was raised as an example of a state doing equity work with a broad intersectional lens, both within populations served and the workforce that supports them. D.C.'s efforts to ensure that there is a culturally and linguistically appropriate front door to services was also raised as an example. New York and California were brought up as doing well in approaching the intersection of people experiencing developmental disabilities with other social and identify factors that influence equity. Another key informant discussed the need to center health literacy within equity work, citing differing understandings of health, medicine, and equity in general as barriers if not parsed out and treated as equal perspectives. One issue that was brought up is the lack of LGBTQ+ data for older adults, people with disabilities, and generally people using HCBS services, an issue that SAGE is working to advance.

Geographical Considerations: One key informant discussed the complexities that various geographical factors create in contributing to inequities.

"But one thing that we've noticed that makes a big difference in terms of strategies at the state level is the extent to which the state is rural versus urban. I mean, this is true on any issue as you probably know. But on direct care workforce issues, it's especially challenging because, I don't know, the workforce capacity question in rural areas is just so dramatically different. And it's become like a major kind of differentiator in terms of policy approaches and strategies is the extent to which the state is rural and it's thinking about that versus kind of a more urban approach. And of course, there's suburban within that. But just to think about that complexity there."

While this was not a prominent theme within interviews, we know it is a complex and very present factors both across and within states that warrants further discussion and investigation.

II. Community Engagement Key Themes

States with an appetite for engagement: Key informants cited a diverse list of states that weren't necessarily standouts for their existing community engagement efforts but demonstrated a promising interest in strengthening their approaches. A wide variety of state entities were cited as demonstrating an interest in community engagement, including state agencies, state legislatures, and governor's offices. The identified states include a wide span of geography and political landscapes.

States cited by multiple key informants:

- Oregon: agency interest and a strong state administration commitment to community engagement principles
- Maine: strong advocacy community and a strong state administration commitment to community engagement principles
- New Mexico: community engagement is a strong priority for new administration across issues, strong legislative opportunities, and strong advocate coalitions

Other states cited by key informants:

- Arizona: new administration friendly to community engagement and strong advocate coalitions
- California
- District of Columbia: "top notch" community engagement
- Illinois
- Indiana
- Iowa: working with a consulting firm to improve community engagement
- Louisiana: strong relationship-building with community-based organizations, especially faith communities; every ARPA-funded project included a community aspect
- Michigan: strong advocacy community
- Minnesota
- North Carolina
- Oklahoma: conducting statewide HCBS feedback forums
- Rhode Island: existing community engagement work around HCBS changes
- Wisconsin: while the state legislature is not particularly receptive, the state's governor is receptive

There were also states cited that don't necessarily have state governments with a strong appetite for community engagement, but do have strong advocacy communities that key informants felt could use support in pushing for meaningful engagement:

- Florida: Advocates are not currently being heard and could use some assistance
- Georgia: government is pursuing a "deliberate attempt to circumvent public engagement" according to one key informant
- Pennsylvania: an appearance of strong community engagement on paper that according to advocates on the ground, is not actually happening
- Tennessee: state has an interest community engagement but unclear if they're interested in following through

States doing well or taking particularly creative approaches: Key informants cited a sizeable list of strong standouts in community engagement, pointing to a diversity of community engagement approaches that could be replicated by other states looking to grow their engagement strategy.

- Arizona: To get a direct understanding of the direct service worker perspective, the state established direct service worker advisory groups. The state was also lauded for its committed approach to engaging with tribal communities.
- California and New York: Multiple key informants cited these states' consistency with engaging with stakeholder communities, which one key informant described as "pretty constant contact."
- Colorado: Multiple key informants cited the state for its consistent, transparent communication with a diversity of stakeholder communities.

"The piece that I appreciate most about Colorado is their transparency and constant outward facing communication with communities. Whether that's monthly webinars. Whether that's some town hall meetings, communication through posting on Facebook, communication through their outward facing website. Those kinds of things of accessibility to information and transparency to communities really is important for me, especially considering that we have a state that's very rural."

- Illinois: This state was pointed to as one that took community engagement seriously through its engagement with existing advisory councils and its engagement with community stakeholders.
- Indiana: The state pursued a strategic, meaningful partnership with the Indiana Minority Health Coalition, which provided a strong foundation for reaching marginalized communities throughout the state.

"Within the coalition, they have different cultural and diverse partners throughout the state that are doing minority health work in Indiana. So, it's a very unique but very thoughtful partnership. And the way they're utilizing them in every aspect of that implementation is extremely admirable."

- Massachusetts: Multiple key informants identified Massachusetts as a strong state. In particular, it was one of the first states to begin surveying HCBS stakeholders, even before CMS issued guidance on community engagement. Their head start allowed for more robust feedback.
- Michigan: The state stood out in its relationships with the advocacy community and its commitment to working with community coalitions.

"Michigan is a state that feels like they're really engaging their community and the organizations that are part of that community. We work with a coalition called the IMPART Alliance. And they're very closely involved with the state. And so, I think that that's the way they ensure. And the coalition has hundreds and hundreds of members, advocates and consumers and workers, nonprofits, employers, payers, etc."

- Minnesota: The state was noted for its strong tribal engagement, to the point of looking at tribal case management.
- Rhode Island: As part of its current statewide LTSS redesign, the state is doing well at incorporating community members in the process, which has enhanced their approach to HCBS ARPA spending.

State Community Engagement Practices: Many states tapped into existing forms of community and stakeholder engagement, such as advisory committees, work groups, councils, and beneficiary advocates. For example, Colorado and Arizona engaged deeply with their state developmental disability councils, while Hawaii pursued community engagement through their existing work on quality improvement. Indiana formed a partnership with the Indiana Minority Health Coalition. States with these existing channels had an advantage in gathering high-quality input under the tight submission deadlines.

"I'm just a proponent of utilizing existing groups in the community that focus on minorities and people who are experiencing disparity to engage the community because they have already that built-in trust and respect of the community. And a lot of times, when the states go directly to individuals and the states have not built up that level of trust, it just falls on flat ears. So, I go back to this Indiana and their use of their minority health coalition, I truly believe that that is really a best practice, to utilize communities and partnerships in that way so that you have voices at the table that are bringing in that information so that you can make those decisions with that trusted voice."

States also engaged the broader public with a mix of surveys and public forums. Multiple states pursued web-based surveys, while others held public meetings that were open to the public. Some states had public comment opportunities.

State Engagement with Specific Community Groups: While there were fewer states cited by key informants as doing specific engagement work, there were nonetheless a few strong examples of targeting specific communities. Illinois and California have the benefit of a unionized direct care workforce, giving them an opportunity to hear directly from direct care workers and address labor issues that hinder direct care workers. Given the complex relationships between unions, levels of civic engagement, and voting behaviors future investigations may be needed to parse out the impact of direct service worker votes, union policy priorities, and the interaction of the two on state endorsement of engagement and equity strategies. In terms of engagement with tribal governments, Arizona, Colorado and Minnesota were mentioned as having strong relationships. Hawai'i made investments in engaging the provider community on quality improvement, engaging them to develop their own quality strategies. They also used ARPA funds to improve their communication strategy with their developmental disability program.

"...I feel Arizona has laid the groundwork and established the relationship with the tribal communities to ensure that there's engagement in those communities. I mean, they prioritized even hiring a consultant in their ARPA plan so that that consultant can make recommendations and strategies on how they'll go forward with the already established relationships."

III. Cross-sector and Governmental Collaboration

Key informants listed a diverse list of states that have strong cultures of cross-sector and governmental collaboration. The common thread among these states was gubernatorial leadership's emphasis on a culture of collaboration, which is vulnerable to changes in gubernatorial administration.

- Alabama: A key informant cited the state as well-coordinated between state Medicaid and its senior services department.
- California: The state's Master Plan on Aging provides a framework for inter-departmental collaboration.
- Colorado: The state was described as strong in leadership and cross-agency collaboration, particularly in working with community partners on the ground.
- Missouri: The state's developmental disabilities director moved from the department of aging director, resulting in the two departments having strong relationships that allowed them to work closely together on their ARPA spending plan implementation.
- Oklahoma: A statewide Long-Term Care Quality Improvement Council meets monthly to make decisions on HCBS services, including ARPA spending plan decisions, and includes its departments of Medicaid, aging, developmental disabilities, human services, and behavioral health.
- Rhode Island: The state convenes an inter-agency group that meets multiple times a week, as well a broader group that meets monthly and includes providers and other state partners.
- Wisconsin: Its state department of health is working with different state leaders to create a portable certification program for direct care workers.
- Indiana, Louisiana, Maryland, Minnesota, Ohio, Oregon, and Pennsylvania: This list of states was noted for their strong culture of interagency collaboration, particularly among mental health and IDD-focused state leaders.

IV. Long-Term Investment

While key informants agreed that states recognized the importance of moving towards long-term investment and building sustainability, there are significant structural barriers to doing so. States were expecting other sources of funding from federal legislation that didn't come (Build Back Better), and it's uncertain if states can expect any other enhanced federal supports moving forward. With the unwinding of the Public Health Emergency happening in the same time of ARPA, state agencies are strained in terms of capacity.

"There's a bandwidth issue within states. Making sure that you're continuing to move apace with the investments within your ARPA spending plan while also contributing and assisting in the unwinding and potentially rendering an awful lot of folks without necessary supports and services."

Amid these challenges, some states are pursuing long-term investments. New York and California are using increased federal funding to eliminate financial eligibility requirements for Medi-Cal and New York Medicaid. New York is also pursuing a $2 wage increase for direct care workers. Like the existing California Master Plan on Aging, New York and New Jersey are both developing master plans that address direct care workforce issues in the long-term. Similarly, Washington has longer-term goals for their Long-Term Care Trust program.

"My general take on that is, you need federal dollars to do this well, and states were really hoping that these federal dollars would come in Build Back Better. They didn't come. So, it is tough to dedicate both from a political will perspective, from a, 'Where do you get the revenue,' perspective to find the state dollars to do all of this."

Other states are building a pathway to make short-term improvements permanent. Nevada, for example, has increased rates for their workforce and is establishing the process for getting legislative approval for permanency. Similarly, Colorado, Illinois and New Mexico are working on establishing permanent funding for many of their ARPA-related improvements.

V. Barriers and Roadblocks

States had to contend with a rapid turnaround in submitting their ARPA spending plans, which limited their ability to engage with stakeholders in the community. The rapid turnaround forced quick decision-making about spending priorities that couldn't be developed further. The short-term nature of the ARPA funding also diminished the ability of states to make innovative, equity-driven choices.

"There's been a pivot in the degree to which ARPA funding is innovative. A lot of that is focused on this idea that we need to recover from COVID. There's been this incredible drain on state resources. ARPA funding was meant to be something that I'm not totally sure it is at this point or can be at this point."

States have significant limitations in their existing data collections that make it particularly hard to identify priorities and target specific populations, a common theme that impacts states beyond HCBS services and ARPA implementation. Data collection requirements are limited, making the baseline data on HCBS populations not particularly detailed. States are hesitant to commit to a targeted approach to advance equity because they do not have the evidence base to back up their strategy. States will need support in improving data collection, particularly in disaggregating data. This will be particularly relevant as states build the evidence base for their legislatures to continue funding ARPA-initiated programs.

"I think that there's almost a little bit of paralysis when I talk to states because they're like, 'We don't even know where to begin and how to target populations because we have no idea what the landscape is in our state.' So, I think that that information, data collection is a crucial part of where some of the states feel like they need a lot of help."

States must contend with the politicization of equity-centered policy work, to the point of having to avoid using the terms "equity" or "disparities" in their spending plans. Many state administrators tasked with ARPA implementation are not political appointees and are hesitant to pursue anything that could be described as "politically charged." States need strategies to advance HCBS initiatives in a neutral, policy programmatic-oriented manner.

VI. Priority Supports and Learnings

Key informant interviewees identified a few supports and learnings that were most pertinent and were eager to have these learnings available to state administrators, advocates, and other stakeholders. From a direct care workforce perspective, one key informant suggested prioritizing data about the direct care workforce, particularly how many workers received increases in pay and/or benefits from ARPA spending increases. Multiple key informants stressed the importance of detailing the challenges and successes of state implementation strategies that were both innovative and equitable. There is limited data about how the implementation process has played out at the individual state level. With the barriers and pressures states faced in pursuing their original ARPA priorities, case studies of how states successfully navigated these challenges are helpful and instructive to other states. Key informants also prioritized learnings on community engagement, particularly regarding HCBS users of color. States need support in identifying community groups and bringing them in to meaningfully participate in decision-making.

"If you find someone, who did it well, what did they do? How can we share that with others when faced with this incredible pressure and circumstance that they were able to do this well? How did they do it I think is important."

In terms of dissemination, there was enthusiasm for webinars and "simple one-pagers" that summarize existing data in a way that advocates can easily utilize. One key informant suggested national-level guidance around key concepts and terms, such as plain language and health literacy. A standardized guide to equity and innovation is critical to building buy-in, particularly for states who have experienced setbacks in achieving their initial ARPA spending agendas.

VII. Priority State Recommendations

Within the eleven key informant interviews, thirty-four states were mentioned and the District of Columbia. Nine states: Arizona, California, Colorado, Connecticut, Illinois, Minnesota, New Mexico, New York and Rhode Island as well as the District of Columbia were recommended to be considered for the project, and Pennsylvania was recommended for further review. Please see the attached table in Appendix B which breaks down each state that was recommended for participation, the number of recommendations, themes discussed in interviews pertaining to the state, and any other applicable notes.

Discussion

Key informant interviews revealed and confirmed important factors to consider when selecting states for this project:

- All states have room to grow in both equity and engagement work.
- States with pre-existing equity and engagement infrastructure fared better both in the quality and sustainability of equity and engagement related initiatives.
- Equity and engagement activities were most commonly related to workforce and technology.
- Hiring consultants, creating positions, and mobilizing grants to community level organizations to work on equity and engagement related initiatives were all tactics states used to navigate the tight timeline.
- State approaches to equity and engagement range from broad cross-agency initiatives to more targeted approaches impacting specific populations and services.

Cross-cutting all lessons learned is the question of what factors and/or combination of factors, bear the most weight in selecting states to participate and why? Even prior to weighing and judging criteria, are there gaps or areas that should be flushed out further?

Community Catalyst

Appendix A: Key Informant Interview Guide

Interview Questions:

1. Are there states that you are aware of that are doing particularly well, or being particularly creative, in centering equity in how ARPA funds are implemented related to HCBS? If yes, who are they and what are they doing?
2. Are there states that you are aware of that have an appetite for centering racial justice and equity in how ARPA funds are implemented related to HCBS but maybe aren't there yet? If yes, who are they and what's happening in those states?
3. Are there states that you are aware of that are doing particularly well, or being particularly creative, around engaging community in how ARPA funds are implemented related to HCBS? If yes, who are they and what are they doing?
4. Are there states that you are aware of that have an appetite for engaging community in how ARPA funds are implemented related to HCBS but maybe aren't there yet? If yes, who are they and what's happening in those states?
5. How did states engage community members in their initial ARPA spending plans? (Surveys, community forums, advisory committees, etc.) Did any of this community engagement result in publicly available data that would be useful for us to know about?
6. We know that states have proposed using ARPA funding to expand, strengthen, and enhance HCBS in the following areas. Are you aware of any innovative practices related to community engagement and centering equity happening in these areas?
    - Provider Supports/Workforce Issues
    - Technology and telehealth
    - Quality improvement
    - Cross-sector partnership related to social determinants of health including housing and employment
    - Additional and expanded HCBS services and eligibility
    - Caregiver supports
    - Supporting transitions to the community
7. We also know that one of the challenges is working collaboratively across different government agencies, do you have any examples of states that are doing this well?
8. We view this as an opportunity to increase long-term community-driven investments in HCBS services, are there states or groups that you are aware of that are thinking similarly?
9. One of the foundational aspects of this project is centering racial equity and health justice in how ARPA funds are implemented through community engagement and other strategies. Are there 2-3 states that you would recommend that are:
    - doing this right AND have room to grow,
    - have an appetite to scale this sort of work
    - And/or would have a lot to share around how to approach this work?

10. Given the focus and timeline of the project, what are the largest barriers or roadblocks you imagine we will face, and do you have any immediate suggestions on how to mitigate those barriers or roadblocks?
11. Given the focus and timeline of the project, what supports and learnings do you feel are most pertinent, and do you have any thoughts on the best way to disseminate those learnings
12. In building our community advisory group and community of practice, what groups and individuals should we be reaching out to? Are there other experts you would recommend we reach out to for a key informant interview?
13. Is there anything we are missing or that would be helpful for us to explore?

Appendix B: Priority State Recommendations

Table 1: Breakdown of Key Informant State Recommendations

State/District	# of Rec	Key Points from Interviews	Things to Note
California	Five	• Equity embedded throughout HCBS, Research, Data and ARPA spending plan • Multiple data dashboards with equity incorporated • Master plan on aging has equity focused goals some are cross walked to workforce goals • Paid family caregivers through consumer directed programs • Community engagement considered somewhere between decent and good • Progress on workforce: Center for Caregiver Advancement to create training programs for direct support workers; tied stipends to workforce training; one time loan repayment and care economy payments • Using ARPA funds to bolster 5 year plan to eliminate financial eligibility requirement or Medicaid • Working across government agencies • Unionized workforce that were able to have a say in the ARPA spending process • Using ARPA funds to support direct technology access for people with disabilities • Community-based residential continuum pilot	• A KII acknowledged it is a unique state compared to others • Another KII discussed that the variation across the state and the sheer number of initiatives could be challenging to bring together.

Minnesota	Three	• Looking at equity across race, ethnicity, language and LGBTQ+ (AS) • Good community engagement • Very broad lens in thinking about attracting and maintaining a diverse and equitable workforce • Established relationships with tribal communities • Good cross governmental collaboration	• A KII included the caveat of further investigating MN's racial equity work first. • Many initiatives so coordinating them all may be a challenge
Washington D.C.	Two	• Strong racial equity focus in state spending plan • Hiring a specific position to oversee health and racial equity in their state government • Investments in in equitable front door to services and access including language accessibility and culturally appropriate care. • Workforce initiatives focusing on equity and inclusion	
New York	Two	• Created advanced role for direct support workers • Created a required minimum wage for direct support workers • Explicit that workforce issues are equity issues and devoting resources to equity in the homecare workforce • Community engagement ranges from decent to good • NYC has created a paid advocate in the division of paid care to monitor workforce issues	

		• Creating master plan on aging and thinking in the long term • Using ARPA funds to bolster 5 year plan to eliminate financial eligibility requirement or Medicaid	
New Mexico	Two	• Explicit about workforce issues being equity issues • New Mexico Caregivers Coalition is very progressive • Opportunity for change in the states • Building infrastructure for community engagement • Thinking about sustainability of ARPA initiatives	• A KII included the caveat of further exploring what's happening in the state first
Illinois	Two	• Supporting undocumented immigrants and unlicensed individuals to join the direct support workforce • Working on community engagement but has room to improve • Engaged stakeholders such as SEIU and outside advocates – especially ensuring women of color within the workforce were heard • Created work force advisory council • Used technology to simplify service application process and matching staff to beneficiary needs • Funds allocated to employment first program for people with disabilities • Some permanent funding increases via ARPA such as wage increases	• A KII included the caveat of further exploring what's happening in the state first

Colorado	Two	• General equity focus and broad HCBS innovation in spending plan • Strong community engagement • Transparency initiatives through stakeholder groups, focus groups and IDD councils • Outward facing communication with communities including data dashboards • Technological innovation • Established relationships with tribal communities • Good cross governmental collaboration • Looking at sustainability across all of their ARPA initiatives • Workforce support via wage increases; allocated over $200 million to direct support workforce innovation	• A KII included the caveat that CO is excelling in some areas and struggling in others.
Connecticut	One	• Potentially setting up data infrastructure related to equity, further investigation needed • Trauma-informed care and racial equity training as part of ARPA	
Arizona	One	• Implemented direct support worker advisory groups and cultural competence trainings • Strong advocacy on the ground and potential interest in engagement with new administrations • Has worked to establish relationships with tribal communities and is hiring a consultant within ARPA	

		spending plan specifically to focus on relationships with tribal communities	
Rhode Island	One	• Generally embedding equity in ARPA spending plan • Created equity challenge grants focused on community/provider level equity initiatives • Health Professional Equity Initiative (HPEI) – chaired by lieutenant governor and includes significant community engagement • HPEI – focused on using ARPA money to expand career pathways for DSW and integrated with local schools, focusing outreach to marginalized communities and communities of color • Contextually undergoing LTSS system redesign with an emphasis on an equity lens • Inter-agency group that meets multiple times a week; broader provider network group meets monthly • Strong empathy and awareness of direct support workforce needs but not necessarily the collective infrastructure and buy in – internal buy in but not statewide.	
Pennsylvania	One w/ caveat to further investigate	• Framework for bolstering direct support workforce in the short and long term t • PA center for Independent Living has advocacy around ensuring community voice is included in ARPA spending plan	

		• Engagement ranges from room to grow to doing well in some areas. • Domestic workers in Philadelphia have built a lot of power and there is the potential for change with new state leadership • Bolstering HCBS data opportunities related to equity • Using some of their ARPA funds to address social determinants of health in collaboration with datasets in community engagement	