

Strategic Approaches to Utilization of American Rescue Plan Act Funds to Support Older Adults

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Policy Points

- > The American Rescue Plan Act (ARPA) could enhance home- and community-based services (HCBS) through its temporary increase in the federal match for certain Medicaid HCBS spending as well as other funding to bolster traditional programs and services.
- > State officials could use the new funding opportunities in ARPA to overcome past challenges in supporting older adults in the community by investing in data systems, affordable housing, the long-term workforce, and more.

ABSTRACT

The American Rescue Plan Act of 2021 (ARPA) offers a landmark opportunity for states to think strategically about building sustainable, person-centered systems and infrastructure for older Americans to age in their communities and homes. This issue brief provides an overview of key direct and indirect provisions of ARPA with implications for addressing both long-standing and emerging needs of older adults for state government officials, including staff of Medicaid, aging, and housing and community development agencies; state legislators and their staff; and advisors to governors. States could leverage the temporary 10 percentage point increase in the federal match for certain Medicaid home- and community-based services (HCBS) spending, as well as funding for health-related social needs and workforce supports that will bolster traditional programs and services delivered through Medicaid and the aging network.

INTRODUCTION

COVID-19 took an outsized toll on older adults. In the United States, nearly 80% of deaths attributed to COVID-19 have occurred among people aged 65 and older.¹ Early outbreaks in nursing homes put a spotlight on the long-standing problems with how our nation delivers long-term services and supports (LTSS) and health care to older Americans, exposing systemic gaps in the infrastructure, financing, and quality of services for the growing number of people living into their 80s, 90s, and beyond.

People living in congregate care settings were at particularly high risk for COVID-19 given the risks of spread in close quarters, and they experienced diminished quality of life and care due to staffing constraints, isolation policies, and lack of formal recognition of essential family caregivers. Older adults living in the community also faced challenges such as the quick transition to virtual care management; a lack of continuity in in-home services; insufficient supports to self-directed services, including hiring, training, and managing workers to provide care; the lack of public health guidance around COVID-19 prevention in the home; the negative effects of social isolation; and high levels of stress and health worries due to particular susceptibility to COVID-19. Many delayed or skipped medical care because of fear of getting the virus.² Inadequate access to community-based services due to the insufficient direct care workforce caused some to go without needed support.

Moreover, older adults make up one of the largest demographic cohorts without access to and meaningful use of the internet. Nearly 22 million older adults in America lack broadband access at home, and that has deepened social divisions and inequalities.³ Finally, continued constraints associated with the cost and accessibility of housing contributed to stress. Before the pandemic, the number of older adult households paying more than a third of their income for housing reached an all-time high of 10.2 million, and many older adults live in environments that do not effectively accommodate their physical needs.⁴

The American Rescue Plan Act of 2021 (ARPA), valued at \$1.9 trillion, was enacted to deliver relief for communities addressing the health, social, and economic fallout of the pandemic.⁵ In this issue brief, we provide an overview of key direct and indirect provisions of ARPA with implications for addressing both long-standing and emerging needs of older adults, with an emphasis on the temporary 10 percentage point increase in the federal match for certain Medicaid HCBS spending. We lay out a framework for state officials considering

cross-sector strategies to leverage the one-time funds to expand supports for older adults in home and community settings. Recognizing that states have already submitted their initial plans for use of the enhanced HCBS match to the Centers for Medicare and Medicaid Services (CMS), we encourage states to think expansively about the future refinement of those plans to optimize opportunities for braiding various strands of ARPA support.

As state officials refine their plans for improving LTSS for older adults, they might consider the following questions:

- How can older adults be better served to remain independent in their homes and communities? What subgroups of aging populations are underserved by existing programs?
- Can the variety of new funding streams be used creatively to overcome past challenges? Although ARPA does not provide new flexibilities, what funding constraints and programmatic rules may be preventing states from providing services to help older adults remain independent in their own homes and communities?
- What partnerships between state government entities and local organizations might be developed or expanded to serve communities more comprehensively?

PROVISIONS TO ADDRESS LONG-TERM SERVICES AND SUPPORTS

Much of the attention paid to ARPA by stakeholders interested in issues affecting older adults has been focused on the enhanced Medicaid HCBS funding. Although this provision represents a historic investment in the Medicaid LTSS delivery system, it is not the only section of ARPA that offers tremendous funding opportunities capable of improving the health of older adult communities and social supports for them. Key provisions to consider are summarized below along with their potential effects for older adults.

Enhanced Matching Rate for Medicaid Home- and Community-Based Services

The ARPA provision to increase the federal matching rate (FMAP) for Medicaid HCBS spending raises the rate by 10 percentage points from April 1, 2021, through March 31, 2022. So long as a state’s overall federal share does not exceed 95%, this increase augments both public health emergency-specific enhancements to HCBS and previously available options. This includes the 6.2% increase available under the [Families First Coronavirus Response Act](#), the 6% increase available under the [Community First Choice](#) option, and the increased match for Medicaid expansion populations. The law requires that states use the additional funds to “implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen” Medicaid HCBS and that they be used for activities “beyond what is available under the [state’s] Medicaid program as of April 1, 2021.”⁶ The law encourages states to take advantage of the enhanced funding to:

- Increase access to HCBS for Medicaid beneficiaries
- Support and protect the HCBS workforce
- Ensure financial stability for HCBS providers
- Accelerate efforts toward LTSS reform

The enhanced FMAP is available for expenditures on a specific set of services, including personal services, rehabilitative services, and more (see Figure 1).

Once states’ HCBS plans are approved by CMS, state officials must submit quarterly plans and an accompanying narrative describing actions until the enhanced FMAPs have been expended. These quarterly updates will allow states to modify and continuously improve strategies in the original plan. States may use the enhanced fund for HCBS investment through March 31, 2024.

Other Supports for Home- and Community-Based Services

In addition to the enhanced FMAP for Medicaid-funded services, ARPA provides funding for several Older Americans Act (OAA) programs to state units on aging. States have the opportunity to braid these sources of funding together for common purposes. These funds include:

- \$504 million for OAA HCBS, including case management, services to address social isolation, health promotion, and disease prevention programs
- \$145 million for the National Family Caregiver Support Program
- \$50 million for grants to public transit systems to improve transportation access for older adults and people with disabilities

Figure 1. HCBS Eligible for Temporary Increased FMAP

Home health care	Alternative benefit plans (section 1937 of the Social Security Act (SSA))	Community First Choice (CFC) (Section 1915(k) of the SSA)
Personal care services		Program of All-Inclusive Care for the Elderly (PACE)
Self-directed personal care	HCBS waiver services (Section 1915(c) of the SSA)	Managed Long-Term Services and Supports (MLTSS)—only state plan and HCBS defined
Case management	State plan HCBS (Section 1915(i) of the SSA)	Medicaid-covered HCBSs delivered via demonstration waivers (Section 1115 of the SSA)
School-based services	Self-directed services (Section 1915(j) of the SSA)	
Rehabilitative services (including mental health and substance use disorder authorized benefits)		
Private-duty nursing (in the home)		

- \$25 million for OAA services for Native American communities
- \$10 million for the Long-Term Care Ombudsman Program
- \$10 million to create a new technical assistance center for kinship families in which the primary caregiver is an adult age 55 or older or the child has one or more disabilities

Supporting Nursing Home Quality and Infection Prevention

ARPA contains two provisions specifically for nursing homes. It authorizes \$250 million to states for strike teams for nursing homes with COVID-19 outbreaks. These teams will assist with clinical care, infection control, or staffing for up to a year after the public health emergency ends. In addition, \$200 million is appropriated for quality improvement organizations to provide infection control and vaccination uptake support to nursing homes during the public health emergency.

PROVISIONS TO ADDRESS AFFORDABLE HOUSING AND SERVICES

Several housing provisions are included in ARPA, totaling nearly \$50 billion, some of which will be directed to states. Many of the housing-specific provisions are targeted at low-income renters and people experiencing homelessness. The objectives are to prevent millions of low-income people, as defined by the Department of Housing and Urban Development (HUD), from losing their homes, and to provide states and cities with resources to house homeless COVID-19-infected persons safely during and after the pandemic.⁷ Although many of the funding provisions do not target programs specifically for older adults, emergency funding for homeowners, renters, and those experiencing homelessness—including older adults—are included in ARPA provisions being administered by HUD.⁸ In addition, the legislation provides \$100 million that will be administered by the nonprofit organization [NeighborWorks](#) to

expand grants to housing-counseling organizations to provide services for households facing housing instability, including older adult households.

Expanding affordable housing for older adults is complicated by the long time horizons and complex financing that go into packaging new low-income tax credit developments, a common approach to providing affordable housing. But there are opportunities other than tax credits to braid Medicaid and other housing supports in useful ways, including, but not limited to:

- [Money Follows the Person](#) initiatives that have paired HCBS with housing vouchers funded through HUD or other sources
- Use of Medicaid waiver funding to support home modifications, assistive technology, smart home approaches, and internet access
- Medicaid-funded transition and tenancy-sustaining (supportive housing) services, which have been authorized by CMS for several years

OTHER PROVISIONS FOR STATE AND LOCAL RELIEF AID

The US Department of the Treasury has launched the Coronavirus State and Local Fiscal Recovery Funds established by ARPA to provide \$350 billion in emergency funding for states, counties, and cities (see Table 1). These relief funds are separate from and in addition to the state dollars that are available through Medicaid and the housing programs discussed previously.

Governmental entities have broad flexibility to decide how best to use this funding to meet the needs of their communities. State officials could therefore consider these funds for a number of investments that can support affordable housing and delivery of health and social supports to older adults.

Eligible governments may request their allocation of Coronavirus State and Local Fiscal Recovery Funds through the [Treasury Submission Portal](#). The funds are being delivered to local governments in

two tranches: half were delivered in May 2021 and the other half will be distributed approximately 12 months later. States with rising unemployment—a net increase of more than 2 percentage points from February 2020 to the latest available data—received their full allocation in a single payment in May. Twenty states and the District of Columbia received their funds in a single allocation.⁹

Recipients of these funds can use them to:

- **Support public health needs**—for example, by funding COVID-19 mitigation efforts, medical expenses, behavioral health care, and certain public health and safety staff
- **Address negative economic impacts caused by the public health emergency**, including economic harms to workers, households, small businesses, impacted industries, and the public sector
- **Replace lost public sector revenue** to provide government services to the extent of the reduction in revenue experienced due to the pandemic
- **Provide premium pay for essential workers**, which is additional pay and support to those who have and will bear the greatest health risks because of their service in critical infrastructure sectors

- **Invest in water, sewer, and broadband infrastructure** to improve access to clean drinking water, support wastewater and stormwater infrastructure, and expand access to broadband internet

PROVISIONS FOR WORKFORCE DEVELOPMENT IMPACTING OLDER ADULTS

Multiple sections of ARPA seek to support the recruitment and retention of essential workers, which may include direct caregivers working in community congregate settings and in home-based care. These workers, who are disproportionately women of color, grappled with low wages, a lack of health care coverage and paid sick benefits, and inadequate options for child care during (and before) the pandemic. In fact, 2.3 million grandparents are primary caregivers and could benefit from access to child care.¹⁰

Child Care and Family Services

One in five direct care workers has a child between the ages of 5 and 17. To ensure these often low-wage workers can afford to stay on the job during hybrid learning and school closures, and as their work hours intensify, they will need access to affordable child care.¹¹

Table 1. Funding Amounts for Coronavirus State and Local Fiscal Recovery Funds

Government Type	Amount (billions)
States and the District of Columbia	\$195.3
Counties	\$65.1
Metropolitan cities	\$45.6
Tribal governments	\$20.0
Territories	\$4.5
Nonentitlement units of local government	\$19.5

ARPA is funding thousands of new subsidized child care slots. A \$39 billion Child Care and Development Block Grant Program will provide \$24 billion in grants to states to fund child care providers and \$15 billion to help provide direct child care aid to low-income families. States are encouraged to distribute the \$24 billion in relief and stabilization funds as quickly as possible to address the immediate crisis for child care providers and protect the existing child care market.

State and Local Recovery Funding Allows for Premium Pay

An allowable use of the \$350 billion for state and local aid is providing premium pay of up to an additional \$13 an hour to “essential” workers, or grants to their employers for such pay. An individual essential worker is capped at receiving no more than \$25,000 in such payments. States must provide certification that they are using funds for premium pay along with following programmatic rules such as their governor’s definition of eligible workers. Essential workers can potentially include direct care staff in home- and community-based settings such as home care aides, personal care assistants, service coordinators, and others who provide critical in-person supports to protect the health and well-being of older adults.

Public Health Workforce

The US Department of Health and Human Services will receive \$7.7 billion to supplement the public health workforce through awards to state and local public health departments. Although this funding might not directly address the critical workforce shortages for providers of services to older adults, a more robust public health workforce can support more vulnerable aspects of communities, which can include older adults with health care and support service needs. Specifically, the department will distribute funds to allow states and localities to hire case investigators, contact tracers, social support specialists, community health workers, public health nurses, epidemiologists, lab personnel, disease intervention

specialists, and communications personnel. An additional \$100 million is available to expand the Medical Reserve Corps, which is a network of volunteers (including medical and public health professionals) that supports emergency response efforts and community health activities.

KEY OPPORTUNITIES

With a tremendous amount of ARPA money now available for state and local governments to implement pandemic recovery plans, and still more forthcoming, states are well positioned to “build back stronger” for all Americans, including older adults.¹² While many provisions come with restrictions specific to existing programs, we believe that strategic and cross-sector use of funds can provide lasting improvements in the systems and infrastructure to support older adults to live longer in their own homes and communities. Based on early feedback from state officials and subject matter experts, we encourage states to think strategically about the use of ARPA funds, whether in combination or alongside each other, to address key themes that can deliver on the promise of community transformation to support older adults and their ability to age in homes and communities.

The areas that we encourage states to explore are:

- Building integrated data systems
- Expanding affordable housing with services
- Enhancing quality measurement and value-based purchasing models
- Developing workforce recruitment and retention strategies
- Ensuring access to internet services and assistive technology
- Aligning Medicaid and Medicare services and payments
- Creating ongoing structures to engage stakeholders in designing innovative and integrative approaches to meet community needs and monitoring their effectiveness over time

Although states have begun to get input into their plans for spending ARPA funds, most are still considering their approaches. What follows are opportunities to explore each of the themes identified as key to supporting older adults.

Building Integrated Data Systems

Policy Questions

- Can states integrate data systems across health, social service, and housing agencies to be more person-centric?
- Can enhanced HCBS FMAP funds be invested to create and modernize care management and service coordination data systems that put the individual and their circles of support at the center?
- Can adverse-event reporting and investigations systems be improved to reduce the abuse, neglect, and exploitation that occur across LTSS and aging services delivery systems?

Older adults with complex needs often receive services from many entities. For example, one person may receive services through a Medicaid provider, a Medicare provider, behavioral health providers, a residential care coordinator, and a social service provider. When care is divided among many separate and uncoordinated programs, each governed by its own policies and procedures, care recipients can experience burden, confusion, and conflicting direction that can lead to fragmentation, unintended gaps in care, duplication of effort, and even harmful events.

Some states have implemented integrated adverse-event or other tracking systems within specific agencies or departments that have served as an important foundation for continuous quality improvement in HCBS, as well as for ensuring that individuals receive timely support for their needs.

Integrated data systems across state agencies or departments could address the lack of coordination and integration of services, improve timely and

consistent adverse-event reporting, and facilitate examination of trends to improve service quality. A critical step toward providing seamless and coordinated support for older adults is positioning them at the center of a more integrated approach, with (1) an accountable entity identified as the lead for purposes of care management, and (2) underlying support from a state data system that integrates information from all available sources.

Expanding Affordable Housing With Services

Policy Questions

- Acknowledging that the funding often associated with affordable housing development comes through HUD, how can states utilize US Treasury relief funds to bolster the supply of affordable housing with services?
- Might states consider allocating more low-income housing tax credits to projects focusing on older adults?
- Can successful resident-centered, enhanced service approaches be expanded or replicated?

Can states invest in data systems in low-income tax credit properties to enable access to telehealth, telemonitoring, and two-way communication between trusted resident service providers and medical providers?

Although federal government programs that subsidize housing for low-income seniors have been in place for decades, they do not come close to meeting the needs of the rapidly growing low-income senior population. In addition, many low-income older adults struggle with paying for food, utilities, prescriptions, and other necessities on small, fixed incomes. Moreover, many of these same older adults are disproportionately burdened by chronic conditions and have complex medical needs. Older adults often have insufficient savings to pay for the help they need to manage their conditions

and are forced to spend down any savings they do have to become eligible for Medicaid long-term care benefits. Medicaid programs can provide housing-related supports largely through services and support allowed in waiver programs and the Money Follows the Person initiative.

Enhancing Quality Measurement and Value-Based Payment Models

Policy Questions

- Can states make investments to develop and test new quality measurement programs in home- and community-based services?
- Should states consider participation in reporting programs such as the [National Core Indicators](#)?
- Can states incentivize new value-based payment models that support older adults to receive the care they want and need in the places they prefer?

Although quality measurement in post-acute care has been established, the COVID-19 pandemic made clear the inadequacies of these measures and processes in ensuring that long-term care settings are safe or healthful. Moreover, quality measurement programs for home- and community-based services are not well developed. States could encourage the expansion of quality assurance systems and infrastructure in both settings through demonstration grant programs and stakeholder engagement processes.

States are increasingly adopting value-based payment models to incentivize high-quality care, better patient experiences, and less costly services. While most Medicaid value-based models are for acute care services, states are beginning to explore value-based purchasing, which rewards providers with incentive payments for the quality of care they provide, for LTSS.¹³ Examples include acuity-based nursing home

reimbursement (paying based on the residents' level of need), adoption of quality metrics in HCBS waivers, and performance-based standards for care management and direct care providers.

Developing and implementing value-based payment models requires an investment in designing payment systems to reward improvements in the quality of care and care coordination. Funding opportunities through ARPA could encourage cross-sector innovations that may include incentives to deliver care and supports in an older adult's home rather than a facility, or "bundled payments" for care episodes that minimize care transitions between settings and maximize older adults' choices of care settings.

Developing Workforce Recruitment and Retention Strategies

Policy Questions

- How can states identify, recruit, and exponentially expand the caregiving workforce so that older adults can live independently for as long as they are able?
- What strategies can states develop to bring back and retain this workforce to support older adults in home- and community-based settings?

As noted earlier, COVID-19 exposed critical weaknesses in the financing for the long-term care workforce that result from long-standing underinvestment in caregiving roles. Home health and nursing home staff, who are often people of color, were among the most heavily impacted by COVID-19. At the same time, these workers are disproportionately underinsured or uninsured. Along with the lack of health care coverage, direct care workers often grappled with low wages, a lack of paid sick benefits, and inadequate options for child care.¹⁴ While there were not enough direct care workers to meet the demand prior to the pandemic, there is now a critical lack of these workers in many areas of the country.

Ensuring Access to Internet Services and Assistive Technology

Policy Question

- Can states address the digital divide and ensure that older adults have access to the technological supports that so many other age groups have relied on before and during the pandemic?

Research shows that more than two of every five Medicare beneficiaries who live in their own homes don't have home access to a computer with a high-speed internet connection, even though digital communication can be particularly valuable when mobility is limited. More than a quarter also don't have a smartphone or other digital device that could fill in the gap.³ As a result, these older adults may not have been able to take advantage of telehealth services or have their health conditions monitored remotely.

Creating Structures to Align Medicaid and Medicare Services and Payments

Policy Questions

- How can states that do not have Medicare and Medicaid financial alignment models in place use one-time-only funding to design state-specific alignment structures, processes, and incentives?
- How can states ensure stakeholder engagement in this design process?

Although CMS has been running model demonstrations to align Medicare and Medicaid in 13 states, a barrier to improving the delivery system for medical care and health-related services and supports for older adults remains the financial misalignment between these two programs.¹⁵ Examples of barriers and misalignments include:

- Lack of consumer literacy around the parameters of Medicare and Medicaid coverage

- Complexity of choosing between traditional and Medicare Advantage plans, and navigating sources of assistance to fill gaps in coverage (Medicare Savings Programs, Medigap plans)
- Lack of data sharing, coordination, and alignment as between the limited, durationally limited home health coverage provided by Medicare and the more extensive LTSS covered by Medicaid
- Lack of seamless enrollment policies
- Overall lack of uptake of options to provide social determinant supports

Creating Ongoing Structures to Engage Stakeholders in Designing Innovative and Integrative Approaches

Policy Questions

- Can states integrate the existing requirements for stakeholder engagement and public comments with additional funding available through ARPA?
- How can these new funding opportunities increase the meaningful dialogue and collaboration across state government agencies, local organizations, and directly with older adults and their families to create more accessible and seamless service and support systems in communities?

A stakeholder engagement process is a common requirement for federal, state, and local funding opportunities for long-term services and support for older adults. States have an opportunity to make stakeholder engagement more valuable by seeking out new partnerships or coordinating on outreach to existing overlapping constituencies, including the communities of people being served. With the ARPA requirement of providing quarterly updates for a state's HCBS spending plan and narrative, states have a built-in timetable to enter into regular stakeholder engagement processes.

States have historically been obligated to develop a state plan on aging in order to receive OAA funds. With the ARPA funding, there is both a need and a real opportunity to develop a stronger system of stakeholder engagement with older adults and those who serve them.

In addition to formalizing a process for gathering input and feedback from interested stakeholders, states could benefit from taking the opportunity to create a far more comprehensive master plan for aging, as has been done in California.¹⁶

CONCLUSION

Realizing the full opportunities that the ARPA funding provides to deliver coordinated services will require partnerships across state executive agencies, state legislatures, and governor's offices and supports for older adults. Although the focus on Medicaid-funded HCBS is evident, several non-Medicaid funding opportunities can also be aligned and braided together to increase the reach of

the dollars beyond the population eligible for Medicaid services. Combining enhanced service funding with improved supportive services such as assistance with housing, child care support for direct service workers, and integrated data systems across federal- and state-funded programs can allow the one-time ARPA funds to have a more lasting impact. Additionally, with the required quarterly updates to the HCBS spending plans and narratives, states have a real opportunity to engage in strategic planning and engagement with older adult stakeholders.

ARPA offers the chance to build sustainable infrastructure and systems to support older adults to live longer in their own homes and communities. State Medicaid, aging, and housing and community development officials, state legislators, and gubernatorial advisors can come together to invest in state-tailored approaches to align and integrate Medicaid and non-Medicaid funding streams to expand supports for older adults in home and community settings that will pay dividends in the future.

NOTES

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