Medicaid and Adult Protective Services: Opportunities and Considerations

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ADvancing States
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Overview of Medicaid and APS Intersections

Medicaid Administrative Claiming

Medicaid Health and Welfare Requirements and APS

Medicaid Services

Thoughts on Future Work
Preliminary data, where available indicates approximately 50% of APS cases involved a victim that was Medicaid eligible*

- 44% of cases with victims did not have data regarding Medicaid eligibility
- Medicaid financing can be used to support APS for these individuals in several ways

Medicaid administrative claiming
- Medicaid critical incident reporting
- Medicaid services

* Source: ACL and the Adult Protective Service Technical Assistance Resource: 2021 data from 19 reporting states
Medicaid Administrative Claiming
What is Administrative Claiming?

Administrative Claiming:

- Funding for the “proper and efficient administration of the [Medicaid] state plan”
- Financed at 50% federal funding

Could apply to certain expenditures and activities performed in support of state Medicaid long-term services
Use of Medicaid Administrative Claiming

Usage of Medicaid Administrative Match as a Funding Source for APS

- No: 20
- Yes: 13
- I am not familiar with Medicaid administrative match: 5
- I don't know, but I'm familiar with Medicaid administrative match: 2

N=40
Information Sharing with Medicaid

Yes: 21
No: 26
N=47
Why Pursue Admin Claiming?

Opportunities to increase Federal matching funds for State operations

Augment resources for functions already being performed

Strengthen collaboration & communication between APS and Medicaid

Develop clear policies and procedures that help connect APS clients with wide range of services
Basic Requirements

- Costs must be “proper and efficient” for the state’s administration of Medicaid state plan
- Claims must come directly from Medicaid agency
- State must ensure that permissible, non-federal funding sources are used to match
- Administrative LTSS costs related to multiple programs must be allocated across each program
- Costs must be supported by adequate source documentation
Overview of 6-Step Process

Step One: State Medicaid Agency Engagement

Step Two: Identify Permissible Non-Federal Matching Funds

Step Three: Identify Activities Potentially Eligible for Medicaid Admin Match

Step Four: Identify Costs of Allowable Activities

Step Five: Establish Contractual Agreements

Step Six: Secure CMS Review and Approval
Intake and Screening
System and staffing for prompt receipt of reports of alleged adult maltreatment of beneficiaries receiving Medicaid services and the screening, prioritization and assignment of cases for follow up.

Follow-up Investigation
Information gathering to determine if maltreatment has occurred in the provision of Medicaid services, assessment of client needs to determine required services or actions necessary for an individual to be safe and remain as independent as possible.

Service Planning
Service planning with the client related to Medicaid-funded services to improve client safety, prevent maltreatment and improve quality of life and ongoing monitoring of service plan. Coordination with Medicaid case managers in making revisions or developing a service plan for Medicaid beneficiaries.

Training
Training activities of APS workers on Medicaid LTSS, including eligibility rules related to Medicaid benefits and health and welfare requirements included in a state’s Medicaid waivers.
Are benefits of match desirable enough to offset requirements & staff work?

Are there activities already occurring that would qualify?

Are existing systems & processes able to produce required documentation?

What relationships exist with Medicaid and/or need strengthening?
Medicaid Health and Welfare
Background: Health and Welfare

CMS/ACL/OIG released a report on HCBS health and welfare that found:

- Ensuring all critical incidents are reported
- Properly recording all reported incidents
- Ensuring incidents were reported at the correct severity level
- Collecting and reviewing all data on critical incidents
- Ensuring all reasonable suspicions of abuse or neglect were reported

The report listed four key components of health and safety in HCBS:

- Reliable incident management and investigation processes
- Audit protocols that ensure compliance with reporting, review, and response requirements
- Effective mortality reviews of unexpected deaths
- Quality assurance mechanisms that ensure the delivery and fiscal integrity of appropriate community-based services.
Medicaid Critical Incident Investigations: How?

• In many cases, Medicaid quality assurance staff do not have background or training in investigation or substantiation
• States are seeking partnerships to better address critical incident response and remediation
• Ongoing CMS emphasis, including “Special Review Team” visits will drive further Medicaid action on this issue
• In states without a strong APS/Medicaid connection, this is an acute opportunity
Establish Protocols:

- Determine role for APS in Medicaid critical incident management
- Develop MOU or other formal agreement on responsibilities and reasonable data sharing
- Leverage Medicaid match to support the activities that address health and welfare

Identify Existing Critical Incident Management Procedures:

- What currently exists in the state?
- What are strengths and weaknesses of existing infrastructure?
Medicaid vs APS Services
APS and Medicaid Services

What should APS finance?

What can be provided via Medicaid?
Services Identified in ARPA APS Spend Plans

- Emergency/Temporary Housing, Moving assistance
- Utility, rent assistance, minor home repair
- Deep cleaning, pest eradication
- Domestic goods, clothing, and provisions
- Food, medications, DME, transportation
- In-home care, respite, transition of care support
- Case management, mental health services
- Legal services, guardianship
<table>
<thead>
<tr>
<th>Authority</th>
<th>Features</th>
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<tbody>
<tr>
<td><strong>State Plan Amendment (SPA)</strong></td>
<td>States may provide HCBS (case management, homemaker/home health aide/personal care services, adult day health, habilitation, respite, day treatment/partial hospitalization, psychosocial rehabilitation, chronic mental health clinic services, and other services approved by the HHS Secretary) to individuals who meet needs-based criteria and have income of up to 150% FPL. States may target populations but must serve all eligible individuals statewide and cannot cap enrollment or impose a waitlist.</td>
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<td><strong>HCBS 1915(i)</strong></td>
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<td><strong>HCBS Waiver</strong></td>
<td>States may cover HCBS (including care management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care) for people at risk of institutional placement. States may use targeting criteria, limit geographic coverage areas, and cap participation. Waivers must demonstrate cost neutrality with Medicaid-funded institutional services and must be renewed each five years.</td>
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<td><strong>1915(c)</strong></td>
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<td><strong>Research and demonstration waiver</strong></td>
<td>States may implement experimental, pilot, or demonstration projects that are likely to assist in promoting Medicaid program objectives (e.g. expanding eligibility, providing services not typically covered by Medicaid, and/or using innovative service delivery systems). States must demonstrate budget neutrality with federal expenditures over the period of the waiver, accept a cap on total expenditures, and renew after an initial five-year period for up to 3 additional years.</td>
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ARPA: Historic Investments in APS

• $86M awarded to states in 8/2021
  – States required to submit Initial Spend Plan
  – States required to create 3-5 year Operational Plan by 1/31/22

• APS Technical Assistance Resource Center
  – Currently providing intensive TA to states

• Additional $100M available in FY 2022
40 Plans: Common Priorities

- Services for clients
- Technology investments incl. equipment
- Training
- Staffing
- Contract expertise
Takeaways

• There remains a disconnect between APS and Medicaid Health & Welfare processes
• State H&W infrastructure development focuses on the IT systems
• Opportunities exist to both enhance APS and strengthen HCBS health and welfare
• Formal engagement and agreements regarding collaboration, roles, & responsibilities an important first step
How to Address Self-Neglect: the Rising Tide of APS Caseloads
### NAMRS: The Data Say

<table>
<thead>
<tr>
<th>Allegation Type</th>
<th>2019</th>
<th>2020</th>
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<tbody>
<tr>
<td>51.0% self-neglect</td>
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<td>49.2% self-neglect</td>
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<tr>
<td>24.0% neglect</td>
<td></td>
<td>24.6% neglect</td>
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<tr>
<td>23.8% exploitation</td>
<td></td>
<td>24.6% exploitation</td>
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<tr>
<td>12.6% physical abuse</td>
<td></td>
<td>13.1% physical abuse</td>
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<tr>
<td>1.6% sexual abuse</td>
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<td>1.5% sexual abuse</td>
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**Some cases have multiples types of abuse**
Need for longer-term support

**Case Management for All Clients**

- 0-25: 22
- 26-50: 13
- 51-75: 8
- 76-100: 4

**Case Management for Clients Experiencing Self-Neglect**

- 0-25: 16
- 26-50: 14
- 51-75: 10
- 76-100: 8

N=47
Next steps when client needs services

What to do with clients in need of services

- Refer the client to Medicaid (provide client information)
- Contact Medicaid on behalf of the client
- Refer the case to Medicaid specialist within APS program
- Refer the client to a community organization (ex. AAA or CIL)
- Assist the client in applying for Medicaid
- Refer the client to Medicaid health plan
Top 5 Shared Categories of Information

1. Results of APS investigation (Client)
2. Critical Incident Management data
3. Health and safety assurances
4. List of shared clients
5. Results of the APS investigation (alleged perpetrator)
People experiencing self-neglect need support beyond closure of an APS case.

What will Medicaid pay for?

What will Medicare pay for?

How should we build policy and programs for longer-term support?

The goal is to make services available, not force people to accept them.
My final riddle:

If states provide intensive and sustainable support, can we:

- Increase use of supportive decision making
- Decrease referrals to guardianship
- Improve health and quality of life
- Decrease healthcare expenditures
- Lengthen community tenure
Questions?
Leadership, innovation, collaboration for state Aging and Disability agencies

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