Aging and Disability Resource Center (ADRC) Business Plan

Name of Operating Entity

Your ADRC Name
Address Line 1
Address Line 2
City, ST ZIP Code
Telephone
Fax
E-Mail

Table of Contents

I. General ADRC Description 1

II. Services 3

III. Marketing Plan 5

IV. Service Forecast 6

V. Operational Plan 10

VI. Management and Organization 26

VII. Financial Plan 29

Sections I and III are written to serve as a template that can be easily adapted by each ADRC. This should only require filling in information in certain sections and modifying text to better fit your effort. Sections IV through VII contain discussions and tools to complete each of these sections. They will require more effort and original writing to complete.

I. General ADRC Description

Philosophy: The ADRC believes in empowering individuals with disabilities of all ages to have greater control over their lives by improving their ability to make informed choices.

Mission Statement: The ADRC will improve access to information and linkages to long term supports and chronic care service for the elderly and persons with *fill in populations to be served* in *fill in geographic coverage areas*. Although the ADRC will have a special focus on providing access to publicly funded services, it will provide information, counseling, and assessment to anyone regardless of income because early intervention may result in better outcomes for the individual and potential savings to Medicaid.

Goals and Objectives: The ADRC has the following goals:

- Identifying and intervening with individuals at risk of entering an institution with the goal of providing them with information and counseling that will allow them to make informed choices about the long term supports they receive.
- Collecting and disseminating timely and accurate information about the availability and quality of services supporting individuals with disabilities.
- Streamlining the intake, assessment, and eligibility determination process for long term support services funded through Medicaid, the Older Americans Act, or state revenue to maximize the likelihood that individuals in the midst of a long term crisis will be able to receive the support they need to stay in the community.
- Collecting comprehensive information about services that individuals with disabilities need or desire and identifying unavailable or insufficiently available services.
- Assisting the state in maximizing the benefit of limited resources by matching needs and preferences of individual with disabilities to the most cost effective setting.

Population to be served: The ADRC will serve older adults and *fill in populations to be served* in *fill in geographic coverage areas*.

Description of environment: The ADRC is operating in an environment affected by the following factors:

- Population aging and increases in survival rates for disabling conditions will increase the number of individuals requiring long term supports and the costs for these services.
- There will always be pressure to contain state and federal spending for these services, although the extent of that pressure will fluctuate over time.

- Pressure from advocacy groups and legal decisions, such as the Olmstead Decision create incentives to provide individuals with disabilities with greater choice about the supports they receive.

- States will require greater ability to match individuals to the most cost-effective service plan and to have data on the individuals they support in order to make informed policy decisions.

The ADRC will be uniquely suited to serve as the primary entrance hub for Medicaid funded long term supports and services. It will be the principal mechanism for allowing states to control costs by using informed choice to divert individuals from institutions to less expensive community settings.

Each ADRC should add a description of unique aspects of the geographic area that the ADRC is serving that will likely impact operations. These factors may include:

- *Presence of large minority, low-income or disadvantaged populations*
- *Rural, suburban, urban make-up*
- *Concentrations of likely users of ADRC, such as Naturally Occurring Retirement Communities (NORCs).*

The plan should also include a description of other aspects of the long term support delivery system that will impact ADRC operations. For example, the ADRC may act as the entry point for managed long term care systems, necessitating that it maintain a certain degree of autonomy from those managed care organizations to prevent conflict of interest issues.

The ADRC's most important strengths and core competencies: The ADRC is uniquely able to fulfill its mission because it serves as the primary gateway to home and community-based long term care services and institutional care. This will ensure that all individuals receiving Medicaid funded long term care will receive assessment and counseling services. Because of this requirement, the providers that serve as the major pathways to long term care will become familiar with the benefits the ADRC can provide and should be expected to refer other individuals in need of long term supports.

Each ADRC should list other strengths and core competencies, including any experience with populations with disabilities, and assessment, counseling and I and R capabilities

Legal form of ownership: The ADRC is a *[Fill in Government agency, Non-profit corporation, for-profit, etc.]* This form was chosen because *[fill in justification for why this legal form was selected].*

II. Services

The ADRC will provide a comprehensive interdisciplinary program that will include the following range of screening, assessment, counseling, and eligibility determination/enrollment services:

- *Intake*: The process through which inquiries are initially answered with the goal of quickly and efficiently routing the individual to the most appropriate information source or type of service.

- *Short-term Stabilization*: Services designed to find stabilizing care for clients in need of urgent or emergency attention. Such clients may be cases of abuse, self-neglect, or a sudden change in the status of their care network. Clients may be directed to services such as emergency medical attention, Adult Protective Services, or short-term housing and care.[1]

- *LTC Needs and Supporting Resources Assessment*: An in-person, written or electronic assessment designed to collect background information; make a functional assessment of the client's current health conditions; and provide a situational assessment of the client's environment, available resources and care currently being provided.

- *Programmatic Eligibility Determination*: The ADRC will assume the function of making the determination that an individual meets the level of care criteria for all publicly funded long term supports including Medicaid *Long Term Care Level of Care Determinations (LTC-LOC)* established by the state in order to be eligible to receive nursing facility or the HCBS waiver services.[2]

- *Benefits Counseling*: One or more counselors will be available to ensure that individuals receive information about and assistance in applying for public and private benefits for which they are eligible. Additionally, benefits counselors will assist with and give advanced training to Resource Center employees regarding the intricacies of eligibility and benefits of public programs.

- *LTC Options Counseling:* Services designed to allow the client to determine the best choice for LTC and service based on the results of the LTC Needs and Resources Assessment, the Financial Eligibility Screen, and the professional expertise of the counselor.

---

[1] Each ADRC should clarify if they intend to offer short-term stabilization (which is sometimes called crisis case management) and alter the definition so that it is consistent with the design of their program. These services can vary along the following lines: (1) criteria for determining who receives the service; (2) the length and intensity of case management provided; and (3) whether any additional services, such as personal care or respite may be made immediately available.

[2] If the ADRC is serving individuals with mental retardation or developmental disabilities this should be modified to also include LOC determinations for ICFs-MR.

- *Linkage to LTC Service*: The ADRC will connect individuals in need of long term supports with the providers of these services. Examples of these activities include enrolling them in an HCBS waiver and coordinating their contact with a case manager.[3]

- *Interaction with Medicaid Eligibility Approval Process*: The ADRC will facilitate the Medicaid approval process. This will include working to streamline the process at the programmatic level and working with individuals on a case by case basis.[4]

- *Data and guidance to the state regarding areas for improvement in the long term support infrastructure:* The ADRC will be in a unique position to understand how well the current array and supply of services and supports matches the needs and preferences of individuals with disabilities. The ADRC will establish mechanisms to track instances in which needs and preferences identified in the assessment and counseling processes are unable to be met because these services are not funded under Medicaid or there is an insufficient supply of providers. A prominent first step will be tracking the time lag between when an individual is approved to receive personal care and when she or he actually begins to receive it.

These services will be offered free of charge to all individuals with the following exceptions…

The Financial Plan section will include greater discussion about cost sharing for more information.

[3] Each ADRC should tailor this language to reflect how they plan to connect individuals to long term supportive services. For example, the ADRC may choose to directly connect an individual eligible for a HCBS waiver to the case manager, while only providing provider contact information to individuals not eligible for Medicaid.

[4] ADRCs may wish to add more specific language about activities that they are undertaking to achieve these goals. Examples of specific initiatives would be to establish presumptive eligibility for Medicaid funded services, assisting individuals to fill out forms or obtain necessary documentation, and co-locating Medicaid eligibility workers with the ADRC.

III. Marketing Plan

The core component of the ADRCs marketing plan will be the requirement that the ADRC must serve as the entry point to all publicly administered long term supports. Because of this requirement, every individual in the populations served by the ADRC that receive either institutional or home and community-based services, including waiver services funded by Medicaid, must be referred to and offered ADRC services.

This requirement creates a strong incentive for providers and other organizations serving the target populations to learn about the value of the ADRC and make referrals. These organizations can be expected to also refer other individuals to the ADRC as they become more familiar with the value that the ADRC provides.

The ADRC will ease the transition to this new eligibility determination process by…

Each ADRC should have a plan for providing training and outreach to the organizations most likely to make referrals for long term support services. The best way to identify these organizations is to examine sources of requests for current LOC-LTC or other eligibility determinations. In addition, identify places that individuals and their families turn to or interact with during a crisis situation. The ADRC can expect that the major group that should receive training in this effort will be hospital discharge planners. Other target organizations are likely to include physicians and their staff, home health and home care agencies, nursing facilities, entities operating HCBS waivers or personal care programs and other social service agencies. The goal of outreach would be to make the information relevant and useful for accomplishing their job.

Another component of the ADRC marketing plan should strive to make ADRCs a highly visible and trusted place where people with disabilities of all ages and income levels can turn for information on the full range of long term support options and single point of entry access to public long term support services and benefits. The ADRC will conduct outreach to ensure that the general public is fully aware of the ADRC and its role in the community long term support system.

The ADRC-TAE Issue Brief: Marketing to External Audiences provides guidance on outreach efforts www.adrc-tae.org/tiki-download_file.php?fileId=361.

IV. Service Forecast

The ADRC will need to establish a forecast of how many clients it is likely to serve once it begins operations. ***Exhibit 1*** provides a sample table that may be useful in understanding how the potential number of clients you are likely to serve will match up with your capacity to provide services.

Exhibit 1: Projected Number of Clients to be Served by the ADRC and Service Capacity

	LTC-LOC Process Only		LOC Process + Outreach			
	Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Quarter	Total Number of Contacts	Assessments	Total Number of Contacts	Assessments	Capacity for I & R	Capacity for Assessment
FY1 Q1						
FY1 Q2						
FY1 Q3						
FY1 Q4						
FY2 Q1						
FY2 Q2						
FY2 Q3						
FY2 Q4						
FY3 Q1						
FY3 Q2						
FY3 Q3						
FY3 Q4						
FY4 Q1						
FY4 Q2						
FY4 Q3						
FY4 Q4						
FY5 Q1						
FY5 Q2						
FY5 Q3						
FY5 Q4						

Data for estimating the number of contacts from the LTC-LOC process may be obtained from the entity currently conducting this process. This entity, which in many states is the Quality Improvement Organization (QIO), should have data on the total number of LOC determinations done in a particular quarter. This should provide relatively accurate data for Column 2. They may have data on the number of inquiries that do not result in a request for a LOC determination that could be used to formulate an estimate for Column 1 (subtract number referred from total number). If they have an estimate, it may be prudent to inflate that number because the individuals that are currently making referrals for LOC determinations (e.g., hospital discharge

planners) may be more likely to refer other individuals once the ADRC has trained them about the services it provides.

If the ADRC has not conducted its own market research, estimates for Columns 3 and 4 could be derived using the experience of the ADRCs in Wisconsin. ***Exhibit 2*** provides information on the number of contacts per 1,000 individuals in the county for three populations with disabilities: elderly, developmental disabilities, and adults with physical disabilities. These numbers can be used to formulate an estimate for column 3. Estimates for the number of contacts related to older adult clients are weighted by the proportion of the county that is ages 65 and over. The other two populations should be weighted by the population ages 18 to 64. Population estimates by age for the counties you serve can be found at http://eire.census.gov/popest/data/counties/CO-EST2002-ASRO-01.php.

Exhibit 2: ADRC Contacts each Month per 1,000 County Population

	Elderly/ Pop 65+	Dev. Disability/ Pop 18-64	Phy. Disability/ Pop 18-64
Fond du Lac	9.86	0.50	0.33
Jackson	12.66	0.13	0.09
Kenosha	13.89	0.17	0.55
La Crosse	16.00	0.29	0.68
Marathon	17.89	0.05	0.49
Milwaukee*	17.58	N/A	N/A
Portage**	23.93	0.45	0.48
Richland	11.19	0.58	0.48
Trempealeau	9.81	0.73	0.51
All Resource Centers	15.53	0.29	0.50

* Milwaukee county only serves the elderly.

** Portage county's high rate of contacts with elderly clients may be attributable to their co-location with a senior center.

Exhibit 3 provides data on the number of assessments each month per 1,000 individuals in the county for three populations with disabilities. These data can be used to develop estimates for Column 4 using the same methodology employed to apply data from Exhibit 2 to Column 3.

Exhibit 3: ADRC Assessments each Month per 1,000 County Population

	Elderly/ Pop 65+	Dev. Disability/ Pop 18-64	Phy. Disability/ Pop 18-64
Fond du Lac	1.31	0.07	0.12
Jackson	2.81	0.80	0.14
Kenosha	1.26	0.05	0.09
La Crosse	2.58	0.11	0.27
Marathon	1.25	0.00	0.01
Milwaukee*	2.10	N/A	N/A
Portage	1.81	0.07	0.08
Richland	0.76	0.13	0.26
Trempealeau	1.13	0.00	0.02
All Resource Centers	1.79	0.08	0.13

* Milwaukee county only serves the elderly.

Please note that there are substantial variations across the counties in Wisconsin. Thus, you may wish to select a county that has implemented an outreach plan similar to the one that you are planning for your ADRC. ***Exhibit 4*** provides summary information on the types of outreach activities in each of the counties.

Exhibit 4: Outreach Activities in Conducted by the ADRCs in Wisconsin

Outreach Strategy	County								
	Fond du Lac	Jackson	Kenosha	La Crosse	Marathon	Milwaukee	Portage	Richland	Trempea-leau
General Public									
RC Literature (brochures, posters, magnets)	x	x	x	x	x	x	x	x	x
Directory of Services Developed and Distributed		x	x		x				
Public Speaking to Community Groups	x	x	x	x	x	x	x	x	x
Presence at Health Fairs	x				x				
Website	x		x		x	x	x		x
Community Info. Sessions		x							
Media									
Radio		x						x	
TV Ad/ Interview Show		x		x					x
Newspaper Ads		x		x					
Newspaper Articles	x		x						
Targeted Outreach									
Hmong Elders Focus Group				x					
Presentations to School System	x			x					

Provider Presentations/ Meetings (Group)		x						x	x
Provider Meetings (Individual)	x			x					
Staff and Budget									
Full time outreach staff						x			
2000 Funds Spent for Outreach (in thousands)		$20.2		$6.6		$1.5		$3.5	$16.7

Source: Quarterly reports submitted by Resource Centers and RC budgets submitted to DHFS by the pilots.

Columns 5 and 6 in ***Exhibit 1*** may be derived from your operational budget. If this is not the case or to serve as a point of comparison, we have provided estimates from the experience of the ADRCs in Wisconsin. ***Exhibit 5*** provides estimates on the amount of time spent on each contact and the number of contacts that each full time employee (FTE) is likely to address each month. To fill out Column 5 multiply the number of I&R FTEs you are planning on employing by the number in the last column in the ***Exhibit. 5***.

Exhibit 5: Estimated Time Allocation for ADRC Information and Referral Contacts in Three Wisconsin Counties

	Intake FTEs	Avg. # Contacts per month	Minutes per contact	Contacts per FTE
Fond du Lac	2.25	243	96	108
La Crosse	1.75	333	55	190
Milwaukee	9.00	3,438	27	382
Total			34	309

Exhibit 6 provides time estimates for how long it takes for each case worker to conduct an assessment. Please note that this calculation assumes that the assessment includes the full range of ADRC services beyond I&R (i.e., assessment, eligibility determination, LTC options counseling, and linkage to services). This information can be used to fill out Column 6 in ***Exhibit 1.***

Exhibit 6: Estimated Time Allocation for ADRC Assessments in Three Wisconsin Counties

	Case Worker FTEs	Avg. # Assessments per month	Hours per assessment	Assessments per FTE
Fond du Lac	4.25	67	11.0	15.8
La Crosse	4.50	116	6.8	25.7
Milwaukee	25.00	317	13.7	12.7
Total			11.7	14.8

V. Operational Plan

Functions

According to the terms and conditions of the grant, the ADRC must fulfill the following functions:

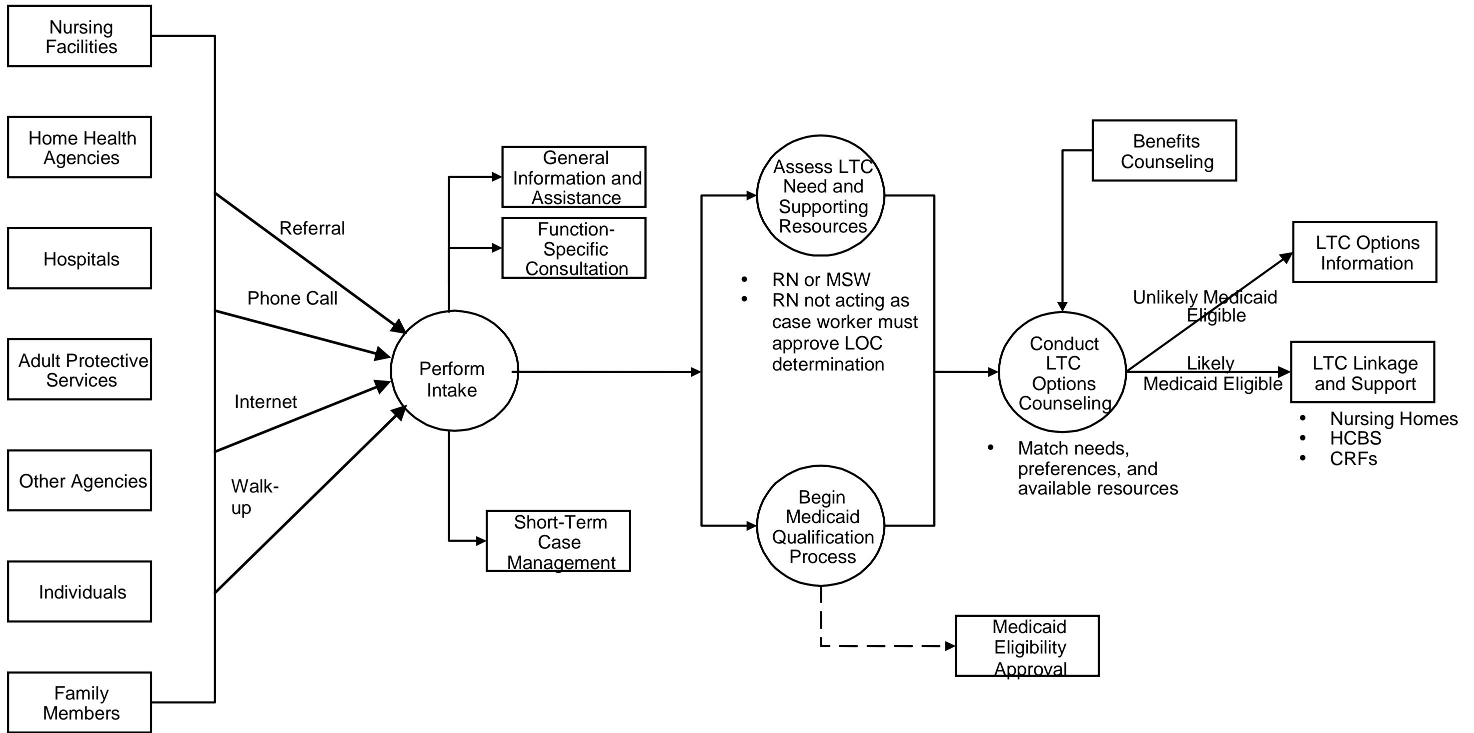
- Intake
- Information and Referral
- Training and outreach to workers at key pathways to long term care (e.g., hospital discharge planners)
- Short term stabilization
- Assessment and eligibility determinations
- LTC options counseling
- Interaction with Medicaid eligibility approval processes
- Linkage to long term supports
- Benefits counseling
- IT maintenance and operations
- Reporting

Additional functions, include:

- General outreach
- Early intervention/disease prevention

Exhibit 7 provides a flowchart detailing how these functions might interrelate.

Exhibit 7: Example ADRC Operational Flowchart



The following section includes a generic description of the requirements of some of the key functions performed by the ADRC. These functions were adapted from the RFP for the ADRC in DC. This RFP was based on lessons learned during the development and implementation of the ADRCs in Wisconsin. Each ADRC should look at these requirements as a template to be adapted to meet their state's individual circumstances and budgetary constraints.

1. Information, Referral and Intake

This function provides a single point of contact to initiate all inquires about LTC and chronic care for persons with disabilities served by the ADRC. The ADRC will develop information and referral protocols and intake procedures and instruments. This phase shall include the following components:

(a.) Provide intake services in a professional manner in a way that is most convenient to the public.

- Act as a knowledgeable and courteous initial client contact that sets the tone for a successful consultation.
- Provide the public with a toll-free number and TTY capabilities. Also have email capabilities.
- Answer all calls with a system that ensures that a caller speaks directly to a person, as opposed to an answering machine or voice mail where practicable.
- Be able to handle calls 24 hours per day. After-hours calls will be routed through a call center answering service, either privately or publicly run, including 2-1-1 services. The ADRC will develop specific training on how operators at the after-hours call center should handle inquiries. A qualified ADRC staff member will be on-call after hours to handle emergency situations.
- Meet physical accessibility requirements and be able to provide information and assistance to walk-ins in a private location.
- Identify if the caller has previously contacted the ADRC, using a database of caller information.

(b.) Identify the problem leading to the inquiry, the knowledge and capacities of the inquirer, and the urgency of the problem, to determine how to approach the information-giving service.

(c.) Receive calls regarding interest in a Functional Assessment from the individual in question, a person acting on behalf of the individual, a hospital, or a LTC facility.

(d.) Explain the services offered by the ADRC, focused on the LTC Needs and Supporting Resources Assessment, LTC Options Counseling, and Benefits Counseling.

(e.) Provide information, which is updated through continual revision at intervals sufficiently frequent to ensure accuracy of information and comprehensiveness of its contents, about services, resources, providers and programs related to LTC or chronic care. It is suggested that this database include all data elements recommended by the Alliance of Information and Referral Systems (AIRS) Standards for Professional Information and Referral. The ADRC should also look to develop satisfaction and quality ratings of providers. See the adrc-tae.org website link for example information assistance websites at http://adrctae.org/tiki-page.php?pageName=I+and+A+Matrix-Public .

(f.) Indicate to the caller those organizations that may be capable of meeting the caller's need(s) if it is not appropriate to refer the caller for the complete range of ADRC services. Assist in linking callers to those alternative resources and organizations. Organizations may include, but are not be limited to:

- Adult Protective Services, abuse, neglect, and exploitation
- Transportation
- Health and nutrition
- Legal and financial matters
- Employment, training, and vocational rehabilitation
- Education, recreation, life enhancement, and volunteerism
- Long-Term Care Ombudsman Program and other advocacy groups
- Other relevant social service hotlines
- Licensing agencies for nursing facilities and other relevant providers

(g.) Refer calls with defined legal issues to the proper authorities. These include calls that must legally be handled by Adult Protective Services (APS), the police department, the fire and emergency medical services, and an agency responsible for serving specific populations with a disability, such as the developmental disability or mental health agency.

(h.) Inform the caller that the services offered by the ADRC are not required in order to receive Medicaid assistance. Additionally, the caller is under no obligation to complete the LTC Options Counseling after undergoing the LTC Needs Assessment, or to undergo the Functional Screen to receive LTC Options Counseling.

(i.) Collect sufficient information (e.g., name, address) and applicable data concerning the caller's condition, environment, or need to allow the ADRC to respond appropriately. This data should be kept in a computerized database. Escalate all calls for urgent or emergency service to the Intake Supervisor. The Intake Supervisor will determine the severity of the case and the best course of action.

(j.) Escalate any call for which the caller's need or requested service cannot be promptly identified. Such calls will be escalated to the Intake Supervisor.

2. Short-term Stabilization

The purpose of this function is to provide stabilization to individuals in need of urgent or emergency services. The ADRC will not attempt to perform any type of care, but act as a resource to link the case to the needed type of service. This service needs to be more than a pass-off to service organizations. The ADRC Case Worker must take the necessary level of ownership to ensure that the situation is stabilized. During this phase, the Case Worker shall perform the following:

(a.) Receive referrals from APS, other government agencies, and individuals regarding an at-risk individual.

(b.) Alert the APS of any cases that are not referred from APS but fall within its legal realm.

(c.) Work with other agencies as appropriate (e.g., Mental Health, Homeless Services).

(d.) Complete a preliminary determination of the type of urgent or emergency services needed in all cases.

(e.) Conduct meetings with the individual needing stabilization in person rather than via phone whenever time permits and is appropriate.

(f.) Call emergency medical service (i.e., 911) for any case involving acute or emergency medical or psychological suffering.

(g.) Attempt to contact the individual's guardian or family member(s) where appropriate.

(h.) Work to assist in locating a suitable temporary place of residence for the individual based on his or her current needs and condition.

3. Case Review

The goal of this function is to match each individual with a Case Worker with the proper expertise for the medical, social, and psychological aspects of the particular case. During this phase a qualified Assessment Supervisor shall, at a minimum:

(a.) Evaluate the case as being more medical or social in nature.

(b.) Assign a Case Worker for the client based on case facts and scheduling (i.e., RN, MSW, or disabilities Case Worker) as soon as possible.

(c.) Forward the case facts and advise the Case Worker as necessary.

(d.) Complete the case review within an hour of the initial intake, when possible.

4. LTC Needs and Supporting Resources Assessment

The purpose of this phase is to evaluate the individual's current health conditions and impairments, and determine what gaps exist in the care currently being provided. The ADRC should have validated assessment instruments prior to start of Resource

Center operations. During this phase a qualified Case Worker shall, at a minimum:

(a.) Arrange for and perform the LTC Needs and Supporting Resources Assessment (Assessment). This will include, but not be limited to, the following requirements:

- Contact the individual by phone to schedule the Assessment within one hour of receiving the case from the Assessment Supervisor.
- Contact by phone the guardian, etc. for any individual that has already had a surrogate decision-maker appointed.
- Perform the Assessment within 48 hours of the initial intake, unless this is inconvenient for the individual. This should occur within 24 hours for individuals currently residing at a hospital.
- Perform the Assessment at the individual's place of residence (e.g., home, hospital, or nursing facility) unless the individual prefers to conduct the assessment at the ADRC.
- Allow and encourage participation in the Assessment from any professional currently overseeing supports provided to the individual, family, or guardian currently caring for or responsible for the individual.
- Strongly encourage the presence of primary caregivers, hospital discharge planners or representative social worker for Assessments occurring in a hospital or institutional setting.

(b.) Collect key background information. This will include, but not be limited to, the following:

- Additional directory information to augment or confirm information received during the Intake process, if necessary.
- Record the individual's preferred LTC or chronic care service/setting.

(c.) Perform a standardized Functional Assessment to evaluate the individual's activities of daily living (ADLs), medical diagnoses, care requirements, cognitive awareness, and behavioral and mental health.

(d.) Perform a standardized Situational Assessment to evaluate the individual's housing and infrastructure status, family support, community support, and risk of abuse or neglect.

(e.) Complete a standardized non-binding inquiry into the individual's income and assets levels. Inform the individual that he or she is under no obligation to complete this form nor does this provide eligibility certification, only an estimate regarding whether the individual may qualify.

(f.) Refer the individual to Short-term Stabilization Services if the individual is deemed to be in immediate risk or in need of emergency services.

(g.) Advise the individual, if appropriate, regarding Medicaid eligibility requirements (e.g., paperwork requirements).

(h.) Initiate the Medicaid eligibility determination process, establishing contact with a Benefits Counselor, if necessary.

(i.) Ensure that the Case Worker has collected sufficient information to complete the Assessments.

(j.) Request an additional case review with the Assessment Supervisor and other Resource Center Case Workers in cases where the primary Case Worker does not have sufficient ability to assess the individual's condition.

(k.) Arrange an assessment by on-call professionals, when necessary. Professionals who may need to be called may include, but are not limited to, medical doctors, psychiatrists, psychologists, occupational therapists, and Alzheimer's specialists.

(l.) Schedule and complete additional assessment visits with additional Case Workers or specialists.

(m.) Inform the individual of the availability of LTC Options Counseling and Benefits Counseling. The Case Worker will schedule an LTC Options Counseling appointment at the time of the Assessment, if possible. If not, scheduling of the appointment should be initiated within one (1) day of completing the Assessment.

5. Benefits Counseling

Benefit Counseling ensures that individuals receive information about and assistance in applying for public and private benefits for which they are eligible. Additionally, the purpose is to assist with and give advanced training to ADRC employees regarding benefits intricacies. As part of this function, the ADRC will:

(a.) Use the Case Worker to serve as a liaison between the individual and the benefits counselor, and to participate in any meeting between the two parties.

(b.) Use a centralized Benefits Counselor with knowledge of the following:

- Medicaid
- Medicare
- Medicare supplement insurance
- Long Term Care financial planning
- Supplemental Security Income (SSI)
- Social Security
- Medical assistance
- Optional State Payment
- Age discrimination in employment
- Homestead tax credit
- Housing problems

– Supportive home services

– Veteran's Administration benefits

– General relief

– Other legal and benefit problems

(c.) Assist Case Workers and individuals with inquiries about Federal and state rules and regulations for government benefits and programs.

(d.) Field basic inquiries and detailed questions from individuals not yet associated with a Case Worker to streamline the work of the state Medicaid eligibility workers.

(e.) Assist potential applicants, as a secondary resource to family members and care providers, in gathering information and completing an application for benefits eligibility.

(f.) Conduct training of ADRC staff on available benefits, eligibility, and how individuals can apply for them.

(g.) Consult with legal support to determine inquiries that require further interpretation of law.

(h.) Identify areas of repeated difficulty for applicants and bring those issues to the attention of the appropriate agency.

6. LTC Options Counseling

The purpose of LTC Options Counseling is to best fit the LTC needs and preferences of the client with the options that are available. During this phase the ADRC shall:

(a.) Provide continuity between the Assessment phase and the Counseling phase by having the Case Worker continue to be the individual's main point of contact.

(b.) Develop materials to facilitate informed choice. Materials will cover, among other areas, common LTC conditions, the realm of LTC Services, available services within the District, eligibility and application processes.

(c.) Assist the individual and family to understand the results of the Functional and Situational Assessments by discussing the following:

– Current and expected impact of the resident's condition(s) on their life

– Type(s) of care (e.g., chore service, attendant care) that will help to alleviate that impact

– Impact of the resident's financial status on care options. At this point it may be necessary to include a Benefits Counselor as part of the counseling discussion.

(d.) Provide impartial information about the LTC services that are available. This step should cover, but not be limited to, the following issues:

– Possible environments in which to receive care (e.g., Home, Nursing Facility, Community Residential Facility, Assisted Living Facility).

- Types of service providers (e.g., Nursing Facility, Home Health Agency) that provide service in a given environment.
- The benefits and drawbacks of each environment and type of service provider.

(e.) Inform the individual of the sources and methods of both public and private payment for LTC or chronic care services, including the Home and Community-Based Waiver benefit and the Medicaid fee-for-service system, as well as the functional and financial criteria for receiving the benefits.

(f.) Provide the individual with a list of providers of their selected service. The following conditions apply:

- The choice of the individual (assuming good cognition) and the individual's family or guardian is the preferable driver of the LTC decision, not the Case Worker.
- The Case Worker must remain objective based on data and experience in the presentation of options.
- The preferred type of service may not be currently available, and an alternative type may have to be selected.

(g.) Maintain a resource database that complies with AIRS Standards and corresponding quality and performance metrics.

(h.) Maintain a database with client tracking function that records the individual's preferred type of service and the actual service in which he or she was placed.

(i.) Complete additional documentation required by the waiver operating and/or Medicaid agency(ies) or other funding sources. This may include a Level of Care, Social Summary, and Pre-Admission Financial Screen among other documents.

(j.) Provide a review and certification of completed Level of Care (LOC) forms. This needs to be conducted by a qualified individual within the ADRC not involved with drafting the Level of Care or the Assessment and/or counseling of the individual in question.

7. Linkage to LTC Services

> *Note: This section assumes that the ADRC will directly facilitate access to LTC services for individuals likely to be eligible for publicly administered supports, while providing referral information and assistance to other individuals. Each ADRC can decide how involved the ADRC case worker will be in connecting individuals to supports and should feel free to alter the language to reflect that decision.*

The ADRC will provide the following services designed to transition the individual from the Assessment and Counseling process into the appropriate LTC solution. As part of this service, the ADRC shall:

(a.) Determine the depth of linkage services that can be provided based on the client's presumed eligibility for publicly funded supports including Medicaid.

- Those individuals already determined or presumed to be eligible for public services will receive hands-on linkage services from the ADRC Case Worker.
- Those clients already denied benefits or presumed not to be eligible will not be turned away. The Case Worker should work to expedite the transition of these clients to organizations accepting private pay.

(b.) In performing linkage services, ensure the following:

- The individual's Case Worker will perform linkage services whenever possible to ensure continuity.
- Linkage services will occur face-to-face as part of the LTC Options Counseling or during a subsequent appointment, if necessary.
- Linkage services will be provided via the telephone or mail if the individual makes such a request.

(c.) Provide the individual and family with provider-specific data regarding their preferred LTC choices.

(d.) Contact the individual's preferred provider in cases in which the individual is likely to be eligible for benefits. This contact will be limited to arranging an appointment or requesting further information, whenever possible.

- On an occasional basis, the ADRC will need to be extremely active in linking a client to the appropriate LTC solution. This will especially be the case if the client does not have an active support system. This effort may include, but is not limited to, facilitating joint conference calls between the ADRC case worker, the client, and a provider representative, or conducting light follow-up with a provider to ensure that a client was successfully enrolled.

(e.) Continue to assist individuals eligible for publicly funded supports in securing an organization to provide LTC services in the event that their preferred provider is not able to accommodate them within a sufficient amount of time given the client's LTC needs.

- There should be no limit to the number of times that an individual may use Resource Center services.

(f.) Provide input to the provider's Plan of Care (POC) for the client or depending on the level of responsibility of the ADRC, development of the POC..

8. Interaction with Medicaid Eligibility Approval Process

Note: This section assumes that the ADRC will co-locate government employees responsible for reviewing and approving eligibility for Medicaid within the ADRC. This is not a requirement of the grant. Each ADRC should develop its own plan for facilitating Medicaid eligibility determinations and alter the language in this section to reflect this plan.

The ADRC will allow employees from the entity responsible for determining Medicaid eligibility to co-locate in the same physical space as the Resource Center, but they will not have any responsibility over the staff. The following provisions outline this relationship:

(a.) The ADRC shall not require or receive rent payments for the space used by Medicaid eligibility employees.

(b.) The ADRC will be required to maintain the physical space and infrastructure used by these employees. This includes use of photocopy and fax machines to be supplied and maintained by the ADRC.

(c.) The agency responsible for Medicaid eligibility determinations will be responsible for supplying the co-located staff with the necessary hardware, software, other information technology, and supplies.

(d.) The Medicaid eligibility employees will not require physical space for more than *fill in number* employees.

(e.) The ADRC will not have responsibility or authority for monitoring or managing the work being performed by the co-located employees.

(f.) The ADRC will attempt to assist Medicaid eligibility employees whenever possible to expedite the Medicaid eligibility approval process. Such activities may include, but not be limited to:

- Answering benefits-related inquiries about available services or the Application process.

- Assisting individuals gather required documentation when the current care provider or individual's family is unable to do so.

(g.) The co-located employees will not have the responsibility or authority for monitoring or managing the work being performed by ADRC staff.

(h.) The ADRC and the agency responsible for Medicaid eligibility determinations will have a dual feedback and reporting role. Each party will be responsible for providing an assessment of the other's ability to perform service and means for improvement. This assessment will be non-binding.

(i.) The ADRC and the Medicaid eligibility employees will be responsible for meeting monthly to discuss operating policies and procedures and areas of improvement.

9. Assistance in continuous improvement projects for the LTC system

The ADRC will be responsible for ongoing assessment, evaluation, and improvement measures to enhance ADRC operations and interaction with the LTC system. The ADRC will be responsible for the following:

(a) Improving the ADRC's operating policies and procedures. Such activities shall include, but not be limited to:

- Assessing current operations and implementing changes and improvements to the operating policies and procedures.
- Following Advisory Board recommendations for changes to operating policies and procedures.

(b) Assessing where state and Federal application for service processes can be streamlined. Processes in question include, but are not limited to, the HCBS Application Process and Medicaid eligibility determination and application. Such processes shall include, but not be limited to:

- Evaluating application components and making recommendations for improvement to the Advisory Board.
- Assessing the application process and making recommendations to the Advisory Board.
- Enacting the above recommendations, where possible. Approval of waiver operating and/or Medicaid agency or additional state and Federal agencies may be required.

(c) Assessing the impact of technology on the ADRC operations. Technology solutions will be applicable in many areas of operations.

10. Futures Planning

The ADRC will establish mechanisms to educate and counsel individuals not immediately in need of long term care about actions that they can take to prepare for the possibility of these needs in the future. This "futures planning" will consist of some or all of the following:

(a) Establishing policies and procedures for identifying individuals who could benefit from futures planning and for offering them these services. This will include training intake workers to identify and refer individuals who could benefit from this planning. In addition, case workers should also inform family members or friends of an individuals referred for assessment that this service is available to them.

(b) Developing or procuring educational materials regarding potential need for long term care in the future.

(c) Developing or procuring educational materials about mechanisms for paying for long term care, including private long term care insurance and reverse mortgage annuities.

(d) Establishing collaborative relationships with the local Senior Health Insurance Program (SHIP).

Personnel

Exhibit 8 provides suggestions for needed ADRC staff by their functions and minimum qualifications. ADRC staff will likely fall into one of the following categories: intake workers, case workers, training and outreach, benefits counselors, administrative staff and consultants.

Intake workers are the individuals that serve as first point of contact. They must be trained to recognize who would benefit from being referred for the full range of services and who only requires information and referral. In addition, they must have sufficient knowledge about the long term support system in the area to fulfill the I&R function.

Case Workers are the individuals who receive individuals referred by the intake worker for a full assessment. If feasible, the ADRC may wish to have two categories of these workers: social workers and nurses. Because many of the individuals being assessed have complex medical conditions, it is necessary to have some level of clinical capacity within the ADRC to perform all or some of the assessment. This can be accomplished in a number of ways, such as:

- An initial review of each case can be done to assess the level of medical complexity. Individuals assessed to be not medically complex can be referred to a case worker with a social work background, while individuals categorized as medically complex are channeled to a case worker with a nursing background.
- All case workers have social work background, but a nurse is available for consultation.
- All case workers have social work background, but a nurse is brought in to conduct a portion of each assessment.
- All case workers have social work background, but a nurse reviews each of the assessments.
- Benefit Counselors will ensure that individuals receive information about and assistance in applying for the public and private benefits for which they are eligible.

In addition, each ADRC will likely want to have arrangements with other individuals to provide clinical consultation as necessary. These consultants may include physicians, psychiatrists,

behavioral specialists, pharmacists, and others. Each ADRC will need to decide whether to contract with these individuals on a consultant basis or to hire them as full or part time staff depending on the expected case load of the ADRC. The ADRC may also wish to consider including these individuals on the ADRC's Advisory Council or other advisory body.

ADRCs should factor in considerations regarding drawing Matching Federal Funds for staff time in determining the qualifications of its staff. In order to obtain certain higher match rates for some activities, staff members are required to have certain licensing provisions. More information regarding this issue will be provided in the Financial Plan section.

Exhibit 8: Suggested ADRC Staff Categories by Function and Minimum Qualifications

Staff Type	Functions	Minimum Qualifications
Intake Worker	Intake Information and Referral	B.A. Training requirement
Case Workers – Social Work	Assessment LTC LOC determinations LTC Options Counseling Interaction with Medicaid Eligibility Approval Linkage to Long Term Supports	BSW or MSW
Case Workers – R.N.	Same as Case Worker – Social Work Plus LTC LOC determinations	LPN or RN
Training and Outreach	Training and Outreach to workers at key pathways to LTC (e.g., hospital discharge planners) Training to ADRC staff	MSW or RN
Benefits Counselor	Benefits Counseling	Master's Degree in related field
Professional Consultants	Providing Consultation on an as needed bases regarding medical, psychological, behavioral, or other issues.	Degree related to type of consultation (e.g., MD, Ph.D., etc.)
Administrative Staff: Director Staff Assistant(s)	Program Management Administrative Support	Master's Degree in related field for Director
Information Technology/Program Reporting	IT Development and Maintenance Program Reporting	Expertise with computer programs selected to support ADRC

Location

Each ADRC will need to make a decision about where to locate the actual ADRC site. In selecting a site, each ADRC should consider the following:

- Although most of the contacts and assessments done by the ADRC will be via telephone or at the location of the individuals with a disability (e.g., their home or a hospital), there will be some individuals who wish to come to the ADRC. Thus, the site should be fully accessible for individuals with disabilities and easily reached using public transportation. This later consideration can be important in metropolitan areas, especially if ADRC case workers going to see clients need to use public transportation.
- Convenient access to other entities that ADRC must work closely with should be considered. For example, if the Medicaid eligibility workers are not co-located with the ADRC, a location that allows for frequent in person interaction will be helpful. Proximity to other partners, such as the agency(ies) operating HCBS waivers and the Medicaid agency should be considered.
- Co-location with other service providers can increase access to services. For example, Portage County in Wisconsin experienced substantially more contacts with elderly clients than other counties because they were co-located with a senior center.

Information Technology Systems

Each ADRC will need to have IT systems that support the following functions:

- Information and Referral
- Client tracking including client intake, needs assessment, care plans, utilization and costs.

These functions can be combined into one system or be separate systems.

The Information and Referral technology system should consist of a searchable database of information about long term care and other providers and other relevant information in the area that the ADRC serves. More information about these requirements is provided in item 1.(e) of the discussion about ADRC Functions.

The client tracking system will be used by the ADRC staff including intake workers and the case workers and in some cases by provider organizations. The intake workers will enter information from individuals contacting the ADRC and search the database to determine if she or he had called before and use information in the database to inform the current contact. This information will be important to understanding who the ADRC is serving so that operations can be fine tuned and to classify contacts by category for conducting time studies necessary for drawing down federal financial participation.

Case workers will use the database to enter assessment and other information and to track outcomes for each client. This database will provide a wealth of information about ADRC operations, as well as, the adequacy of the current network of long term supports to meet the needs and preferences of individuals with disabilities receiving ADRC services. ADRCs may consider having two tracking databases, one for intake workers and one for case workers.

However, if the ADRC chooses to go this route, they should have a mechanism for transferring information from one database to another.

ADRCs are likely to find that having an IT system that supports functions such as web-based entry and searching and the ability to hold and analyze larger amounts of information will become necessary. At this point, it will probably be necessary to hire an outside contractor to develop or adapt a system. The ADRC-TAE.org website has several resource that may be useful in this planning and selection process found at http://adrctae.org/tiki-page.php?pageName=IT+and+MIS.

In developing this system, it will be important to consider linkages to other relevant databases, such as the Medicaid Management Information System (MMIS) and an IT system that supports ongoing case management, such as a system used by HCBS waiver case managers. Linking to other databases will allow for automation of approvals for Medicaid waivers and other services and allow ADRC intake and case workers to view what services an individual is already receiving.

VI. Management and Organization

In designing a management and organizational plan, it will be important to consider not only the key functions the ADRC performs, but where the ADRC resides in the larger long term care delivery system. The ADRC is situated as a crucial intersection that affects the movement of individuals with disabilities to publicly funded long term supports, most notably Medicaid funded institutional and home and community-based services.

In most cases, these individuals will be referred to the ADRC by providers of services that have interests that may or may not be consistent with the interests of the individual with a disability. For example, nursing facilities may reluctantly refer an individual to the ADRC recognizing that the individual may choose another setting because the ADRC approves the LOC determination crucial to receiving Medicaid funding. Hospital discharge planners have an incentive to refer individuals to the ADRC so that they may reduce a length of stay be more quickly moving an individual to another setting. Government agencies have an interest in an ADRC because it can be an effective tool for trying to shift individuals to more cost effective settings and to better understand weaknesses in the current array of services available.

These multiple concerns require that the ADRC have a strong and active advisory body that is guiding the development of the ADRC and ensuring that key stakeholders continue to support the ADRC's work and funding.

Exhibit 9 provides a sample organizational chart for an ADRC. This chart includes a primary role for an advisory body. The exhibit also allows for a project director and supervisors for the ADRC's major functional responsibilities. This chart is only meant to serve as a skeletal framework and it is anticipated that each ADRC will make substantial modifications to reflect its individual requirements and capabilities of its staff. For example, if your ADRC includes state or local level planning committees or issues specific work groups that provide input into the development and implementation of the ADRC these should be included in the organizational chart.

Exhibit 9: Sample ADRC Organizational Chart

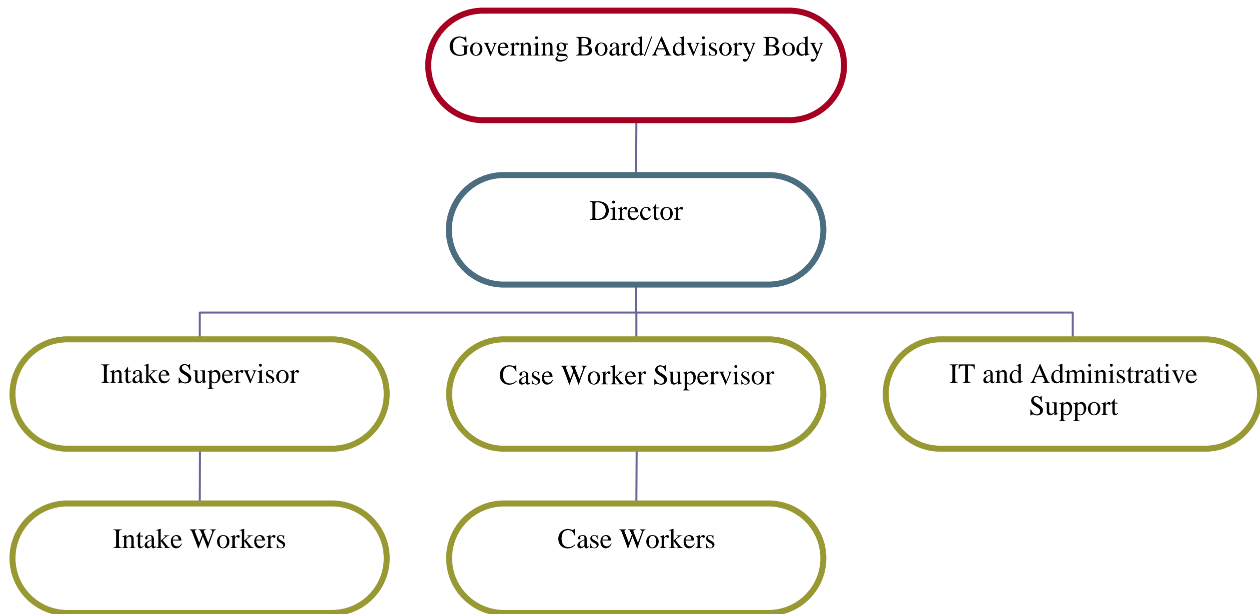
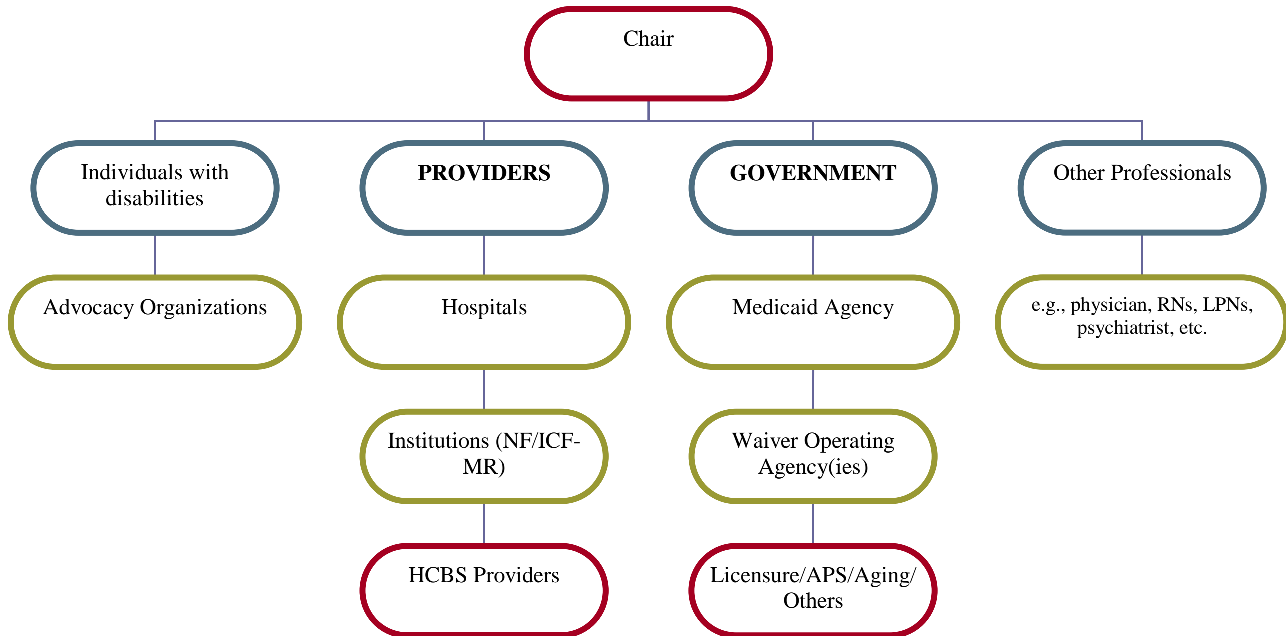


Exhibit 10 presents proposed membership categories for an ADRC Advisory Board. The Advisory Board should have representation from all stakeholders including individuals with disabilities and their advocates, providers, and government. The ADRC may wish to include other individuals who have regular interactions with the ADRC, such as physician consultants.

Exhibit 10: Proposed Membership Categories for ADRC Advisory Board



Each ADRC may wish to consider structuring the Advisory Board so that individuals with disabilities and their advocates represent a plurality or a majority for any votes that are taken. This will help ensure that the ADRC remains true to its central mission of providing individuals with disabilities with an efficient and objective source of information about and access to long term care services.

Each ADRC will also need to define the roles and authority of the Advisory Board. The ADRC may choose to use the advisory body in an advisory capacity regarding operations and other issues or it may provide it with some degree of authority to approve or disapprove ADRC policies and decisions. The lead state agency should have ultimate authority over the program and its Advisory Board

VII. Financial Plan

Each ADRC's financial plan will consist of two major components: an operating budget and a plan for securing revenues. This section focuses primarily on providing assistance with the plan for securing revenues. This effort will likely have three foci: (1) creating a business case to justify the investment of state funds; (2) securing the maximum amount of federal financial participation (FFP) and; (3) obtaining additional funding from other sources.

Operating Budget

Each ADRC's operating budget is likely to include the following components:

- Personnel
  - Administrative Staff
  - Benefits Counselor
  - Case Manager
  - Information and Referral
  - Outreach
  - Project Manager
- Rental/Lease
- Functional Screen and/or Assessment
- Telephone
- Education/Outreach
- Supplies
- Maintenance
- IT
- Contractual
- Brief Services
- All Other Expenses

Plans for Securing Revenues to Cover Operating Costs

Each ADRC will need to develop a plan to sustain operations over time. ADRCs may draw from several funding sources, including:

- State Funds
- Matching Federal Medicaid Funds
- Other Federal Funds

- Private Donations
- Cost Sharing
- Spin-off Services/Public-Private Partnerships

The ADRC is designed to serve as the gateway to publicly-funded long-term care services. Because the majority of this funding is likely to be Medicaid, it is likely that the majority of the funding for operating the ADRC will come from state funds and matching federal Medicaid dollars. Thus, the ADRC will likely need to create a business case for these funds. We discuss options for achieving this goal in the first section.

To minimize reliance on state funds, the ADRC will want to maximize the ability to draw down federal financial participation and explore other sources of revenue. Therefore, we provide discussions of cost sharing and other sources for securing additional revenues.

Making the Business Case for Securing State Funds

Most states are required to make a business case or provide a fiscal impact statement (FIS) when implementing a new program or expanding an existing one. Requirements for a business case or a FIS differ by state, but typically they compare costs for operating the program against potential savings that will offset some or all of these costs, and other potential benefits (e.g., keeping people out of institutions, etc.). Often times, states require that these estimates be projected for multiple fiscal years (e.g., a five year projection).

A business case or a FIS for an ADRC will compare the costs associated with operating the ADRC against savings produced by the ADRC. Potential savings include the following:

- Functions currently funded by the state that are to be assumed by the ADRC; and
- Analysis of savings to the state associated with implementation of the ADRC, such as:
  - Diversions from institutions;
  - Diversions from Medicaid; and
  - Greater ability to influence the delivery system (e.g., efficiencies gained from identifying high risk individuals and channeling them to appropriate programs).

Another major component of this analysis will be the extent to which the ADRC can draw down matching federal financial participation (FFP) to pay for operating costs of the ADRC. This issue is discussed in greater detail in the next section.

Counting costs for current functions assumed by the ADRC. ADRCs are fulfilling all or part of several functions for the Medicaid program, including activities associated with Medicaid eligibility determinations, long-term care level of care determinations, and assistance and outreach. Therefore, it is reasonable that state funds will be a major component of funding for ADRC operating costs because: (1) funding of the ADRC involves, to some extent, a reorganization of functions that are currently being paid by the State; and (2) the ADRC will potentially result in some savings of Medicaid dollars. To draw down FFP for Medicaid-funded institutional or home and community-based waiver care, states must assess whether an individual

meets the hospital, nursing facility, or ICF-MR level of care and make an eligibility determination. States often delegate these functions to a Quality Improvement Organization (QIO)[5]. If the ADRC assumes both the assessment and eligibility functions, it would be logical that the corresponding budgets should shift to the ADRC.[6] [7] The ADRC may also assume additional functions that had been performed by other state agencies or under different contracts, such as outreach and education about Medicaid long-term care services and assistance in Medicaid eligibility determinations. The business case should include all of these costs as offsets against the ADRC's operating costs.

Savings from diversions from institutions. One of the primary goals of an ADRC is to intervene in the current flow of individuals from the community into institutions to delay or prevent the use of institutions. Because the ADRC will allow the state to better identify and target interventions to individuals at high risk of institutionalization and remove other barriers to these individuals accessing community-based services (e.g., streamlining the eligibility process), it is reasonable to assume that the ADRC will result in some individuals being served in less expensive community settings.

A simplistic calculation for estimating these savings could be as follows:

(Number of people diverted from institutions because of ADRC)*

(Average institutional cost – average HCBS cost)) – ADRC operating costs

Average institutional and HCBS costs can be relatively easily obtained using Medicaid claims data (the Medicaid agency is required to submit this information on an annual basis using CMS Form 372), however these estimates may not adjust for possible differences in the severity of disability between individuals in the different settings.[8] Estimating the number of individuals diverted will likely be more difficult. Once the ADRC has begun operations, it can track outcomes for referrals and compare these to experience before the ADRC began operations or the experience of a comparable county or service area.

Prospectively estimating the effect of diversions and impacts of the ADRC on cost is difficult.[9] To the extent that the ADRC intervenes in the pathways to institutions as opposed to general outreach efforts, it should help in targeting and diverting individuals at the highest risk of institutionalization and minimize any woodwork effect (when these individuals are already receiving or in the process of obtaining services). In addition, the effectiveness of the ADRC at diverting individuals from institutions may also be affected by other factors, such as the supply of institutional beds and direct care community workers.

---

5 QIOs were formerly known as Peer Review Organizations or PROs.

6 In some cases, it may be necessary to alter a contract with the existing entity performing the assessment and/or eligibility determination functions. In addition, there may be barriers related to having to transfer budgets across agencies. This may delay or prevent the ADRC from receiving these funds.

7 The actual eligibility determination for Medicaid or for a home and community-based services waiver is a function of the Medicaid agency itself. See 42 CFR 431.10 However, Medicaid may use the ADRC to recommend decisions. The decision is that of the Medicaid agency, and any appeals must be directed to it. See 42 CFR Part 431 Subpart E.

8 Section 1915(c)(7)(A) of the Social Security Act allows states to estimate the costs of a target group that is less than "all individuals at X level of care." If a waiver uses targeted data in its estimates for the CMS Form 372, these data may reflect severity of condition.

9 An Issue Brief about institutional diversions and transitions and the difficulty of accurately determining diversions was prepared by ADRC-TAE staff and can be found on ADRC-TAE.org under Resources by Type, Issue Briefs.

It is possible to present a simplistic fiscal impact statement that demonstrates the number of diversions necessary to cover the cost of operating the ADRC and comparing that number to the total number of people applying for Medicaid funded long-term care. For example, an ADRC may have an annual operating cost of $1 million to serve an area that has approximately 1,000 individuals entering an institution and 500 individuals entering a HCBS waiver on an annual basis. Thus, 33% of individuals go into HCBS waivers rather than institutions. The average cost of the institution is $50,000 while the average waiver cost is $14,000 (a difference of $36,000). Thus, the ADRC would need to divert approximately 28 individuals over the year to cover its operating costs. This translates to a less than two percentage point increase in the percentage of individuals going to HCBS rather than an institution (35%).

Savings from Diversions from Medicaid. The ADRC may also argue that it will produce savings by keeping some individuals off of Medicaid altogether. Some individuals who receive ADRC services and are at risk of spending down to become Medicaid eligible may end up receiving HCBS services that are less expensive than an institution. As a result of services provided by the ADRC, some of these individuals will likely choose to receive HCBS rather than going into an institution. The lower cost of the HCBS services may result in their spending down their assets at a slower rate or may even be sustainable on their current income resulting in them never becoming eligible for Medicaid or becoming eligible at a much later time. For example, an individual with $1,500 a month in income and $22,000 worth of countable assets who is diverted to an assisted living facility at $2,000 a month rather than going into a nursing facility at $4,000 will be able to pay for her services without the assistance of Medicaid for an additional 2 years and 8 months.

Securing Matching Federal Medicaid Funds

Because the ADRC is fulfilling several functions key to efficient operation of the Medicaid program, it will likely be eligible to receive matching federal financial participation (FFP) for these administrative functions. When developing a plan to secure FFP, each ADRC should understand the following:

- Functions for which administrative FFP is available at;
- The operational requirements necessary to secure FFP and pass a state or federal audit; and
- When and how to work with the designated State Medicaid Agency to secure federal approval.

Functions potentially eligible for FFP: Many, if not most, of the ADRC functions are potentially eligible for matching Medicaid administrative funds. States can receive FFP from the federal government for costs associated with the "efficient and effective" administration of the Medicaid program. Generally the administrative match rate is 50%.[10] Medicaid administration activities can include the following:

---

[10] Higher match rates theoretically could be obtained, such as compensation and training of skilled professional medical personnel performing administrative tasks that are medically related. Typically, these rates have been applied to utilization reviews.

- outreach and enrollment,
- case management,
- provider monitoring,
- planning and development,
- network development,
- auditing, and
- quality improvement activities.

While Medicaid must be managed by a "single state agency," that entity is free to subcontract these administrative functions.[11] Thus, regardless of whether the ADRC is a state or local government agency or a private contractor it may be eligible for FFP. All FFP must be drawn down through the Medicaid agency. Thus, if the ADRC is operated by an entity other than the Medicaid agency, arrangements must be made for FFP to flow through the Medicaid agency to the ADRC.

Most of the relevant ADRC functions for which FFP may be available will likely fall into the outreach and enrollment category, but some of the other categories are also relevant. ***Exhibit 11*** provides a breakdown of the potential to secure FFP for core ADRC functions.

Exhibit 11: ADRC Functions by Potential for Medicaid Administrative Match

ADRC Function	Potential Ability to Receive Medicaid Administrative Match
Outreach	**Yes, if outreach emphasizes access to Medicaid program**
Information, Referral and Intake	**Yes, if functions discuss Medicaid as potential service or if provided to someone who is Medicaid eligible**
Short-term Stabilization	**Yes, if the individual is Medicaid eligible and the activities are related to connecting individuals to Medicaid funded services. May also be eligible if funded as Targeted Case Management under the Medicaid State Plan.**
Case Review	**Yes, if individual is Medicaid eligible or if part of Medicaid eligibility determination process**
LTC Needs and Supporting Resources Assessment	**Yes, if individual is Medicaid eligible or if part of Medicaid eligibility determination process**

Exhibit 11: ADRC Functions by Potential for Medicaid Administrative Match, continued

ADRC Function	Potential Ability to Receive Medicaid Administrative Match

[11] It is important to note that because of requirements included in 42 CFR 431.10(3), the Medicaid agency must retain authority and responsibility for the functions. Thus, although the Medicaid agency may subcontract these functions, they are still responsible for making final decisions regarding appeals and program design.

Benefits Counseling	**Yes, if individual is Medicaid eligible or if part of Medicaid eligibility determination process**
LTC Options Counseling	**Yes, if individual is Medicaid eligible or if part of Medicaid eligibility determination process**
Linkage to LTC Services	**Yes, if individual is Medicaid eligible**
Interaction with Medicaid Eligibility Approval Process	**Yes**
Assistance in continuous improvement projects for the LTC system	**Yes, if effort impacts Medicaid services and beneficiaries**
Futures Planning	**No**[12]

Generally, the ADRC could receive FFP for services provided to someone who is Medicaid eligible. How the state and the ADRC define the eligibility determination process may affect the ability to draw down FFP for individuals who are ultimately determined not to be Medicaid eligible. For example, if this process is narrowly defined as simply completing the Medicaid application and the level of care determination, then the ADRC will not be able to draw down FFP for functions such as LTC options and benefits counseling for individuals who are not determined to be Medicaid eligible. However, if the state defines these functions as being an integral part of its process for determining whether an individual is eligible for Medicaid, it could draw down FFP regardless of whether or not an individual is ultimately determined to be eligible.

This broader interpretation of the eligibility determination process can be justified because eligibility criteria are often different for individuals served in an institution or under a 1915(c) waiver than for the regular Medicaid program.[13] Thus, because an individual may only be eligible if he or she chooses to go into the waiver or another service that has a more liberal eligibility process and the individual must make a choice of this service over what could be offered under the state plan, it could be reasonably argued that it is proper for the state to offer counseling on that choice as part of the eligibility determination process.

[12] FFP could potentially be drawn down for providing futures planning for Medicaid eligible individuals. However, it is unlikely that these individuals would benefit from this service. The possible exception to this could be educating individuals about Reverse Annuity Mortgages (RAM). In this scenario, Medicaid eligible individuals would be informed of mechanisms to obtain a RAM rather than relying on Medicaid to pay for the long term care bills. This could be helpful to individuals who prefer not to receive Medicaid benefits or face long waiting lists for home and community-based services offered under a 1915(c) waiver.

[13] States are allowed to set more liberal financial eligibility for individuals in institutions and the corresponding 1915(c) waivers. Thus, individuals would need to select the institution or the waiver over the traditional Medicaid program for this more liberal criterion to apply.

Operational Requirements for Securing Match

CMS has provided the following guidance to ADRCs seeking to draw down federal match: "The state should include their costs in the cost allocation plan that it submits annually to HHS. Costs must be allocated according to the amount of time/effort/fixed cost attributed to each program that they serve. The Medicaid agency is experienced in computing these costs, and can provide direction as to how to proceed."[14]

Although the designated Medicaid agency will submit the cost allocation plan, in most cases, that agency will expect the ADRC to provide components that can be inserted into that plan. The Medicaid agency will then review and approve the proposed language and include it in the state's plan. The following two documents provide parameters for developing a cost allocation plan:

- Relevant federal regulations can be found in CFR 45 section 95 at http://frwebgate6.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=97448670832+2+0+0&WAISaction=retrieve.
- Additional guidance is found in Office of Management and Budget (OMB) Circular A-87, "General Principles for Determining Allowable Costs", http://www.whitehouse.gov/omb/circulars/a087/a87_2004.html.

DHHS has developed a document entitled, "A Guide for State and Local Government Agencies: Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Grants and Contracts with the Federal Government." It is available at: http://permanent.access.gpo.gov/websites/www.hhs.gov/grantsnet/state/asmbc10.pdf. This document provides greater detail regarding the specifics of a cost allocation plan.

CMS has published guidance for claiming administrative match for school based programs at: http://www.cms.hhs.gov/medicaid/schools/macguide.pdf. While this guide is targeted to programs that differ from an ADRC, the discussion of the infrastructure necessary to claim FFP for the administration of a program is relevant.

Below we include text in italics from this document; text was selected to highlight the principle requirements that each ADRC will need to meet to draw down Medicaid administrative FFP. We also provide links to resources that may be helpful in meeting these requirements

- **The ADRC must have an interagency agreement with the single state Medicaid agency:** *An interagency agreement, which describes and defines the relationships between the state Medicaid agency, the state Department of Education and/or the school district or local entity conducting the activities* [in this case, the ADRC], *must be in place in order to claim federal matching funds.*

  The state Medicaid agency is the only entity that may submit claims to CMS to receive FFP for allowable Medicaid costs. This requirement necessitates that every participating

[14] E-mail provided to The Lewin Group by Mary Clarkson, CMSO Division of Benefits, Coverage and Payment.

agency be covered, either directly or indirectly, through an interagency agreement, but there is no need for duplicative or overlapping agreements.

Examples of interagency agreements can be found at the following websites:

- http://www.greenbush.org/Spectra/SDAC_materials/SDAC%20IAA.doc
- http://www.education.ky.gov/NR/rdonlyres/e35frbx7myxstgjoadlmqop6atqdyybf3q6l4xomny2pqsjcp6luzd55vxv272eyo6ctrwcj6jzlf4jq5fh4tozwqpb/SBACDistrictAgreement.rtf

- **ADRCs must conduct time studies** (this issue is discussed in greater detail below)**:** *The time study is the primary mechanism for identifying and categorizing Medicaid administrative activities performed by school or school district employees* [in this case, the ADRC]. *The time study also serves as the basis for developing claims for the costs of administrative activities that may be properly reimbursed under Medicaid.*

  - The CMS guide provides greater detail on the requirements necessary to conduct a time study.
  - California produced a guide that includes detailed instructions for conducting a time study. This documentation could be adapted to meet the needs of an ADRC.[15] This document is titled, "Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2004-05, Section 9 – Federal Financial Participation," California Department of Health Services, Children's Medical Services Branch. The full report can be accessed at: http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/cms/informationnotices/2004/cmsin0405/cmsin0405.htm.

- **ADRCs must not claim FFP for functions for which they are already receiving reimbursement:** *Federal, state and local governmental resources should be expended in the most cost-effective manner possible. In determining the administrative costs that are reimbursable under Medicaid, duplicate payments are* ***not*** *allowable. That is, states may not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative mechanism or funding source. The state must provide assurances to CMS of non-duplication through its administrative claims and the claiming process. Furthermore, in no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost of that program or claiming unit, including state, local, and federal funds.*

Federal regulations provide flexibility regarding how time studies can be conducted and allow a state to propose an alternative methodology to conducting a time study. Also, a time study is not necessary if 100 percent of an individual's time is spent doing Medicaid related activities for which FFP will be claimed at the 50% match rate. The designated state Medicaid agency and CMS must approve the methodology and it should be included as part of your state's cost

[15] California's guide is an available resource but has not been approved by CMS. Each ADRC should have its designated state Medicaid agency review and approve any time study that it develops.

allocation plan. Below we briefly discuss operational issues related to securing FFP for each of the core ADRC functions:

- Outreach – Outreach activities may be tracked by separating efforts that emphasize the ADRC as the access point for Medicaid funded long-term care from those that do not. A time study may not be necessary if: (1) all outreach activities emphasize access to Medicaid and (2) the individual(s) conducting these activities do not allocate a portion of their time to non-Medicaid related activities.

- Information and Referral– Many I&R activities can be viewed as outreach activities because they are providing information to individuals about services provided by the Medicaid program. The ADRC may be eligible to claim FFP if one of the two following conditions are met: (1) the interaction (typically a telephone call) discusses Medicaid, such as whether the person may be eligible for Medicaid or providing information about a home and community-based waiver or Medicaid funded institutional care or (2) the interaction occurs with someone who is already Medicaid eligible. Therefore, the ADRC will likely want to have a mechanism for tracking whether these interactions are Medicaid related and/or the individual is Medicaid eligible.[16]

  The next challenge is translating these interactions into units of time. This could be done in a variety of ways. For example, individuals could complete periodic time studies to track the portion of their time spent on Medicaid or non-Medicaid related interactions. The ADRC could also track the amount of time spent for each interaction (e.g., including amount of time on the tracking form).

  If the ADRC practice is not to ask whether individuals are Medicaid eligible or not emphasize Medicaid related services, it may still be able to draw down FFP. For example, the ADRCs in Wisconsin only track the amount of time spent on I&R. Then they divide this time by the proportion of Medicaid eligibles in the region that the ADRC serves and only claims FFP on this proportion. An alternative approach would be to conduct more detailed tracking, which would require additional infrastructure.

- **Short-term Stabilization –** FFP can be drawn down for this function to the extent that short-term stabilization consists of activities that identify immediate needs and accelerates access to Medicaid funded services to address these needs for Medicaid eligible individuals. In most cases, the ADRC will want to conduct time studies that identify which of the individuals receiving these services are Medicaid eligible and which activities are related to connecting these individuals to Medicaid funded services. For example, time spent assisting someone in crisis locating Medicaid funded personal care services could be claimable, but time spent making a referral to adult protective services would not be. It will be important that the time study methodology include the capability of identifying individuals in the process of having their Medicaid eligibility determined.

---

[16] The ADRC should have a method to verify that an individual is Medicaid eligible. In addition, an individual cannot be required to divulge his or her Medicaid status as part of the I&R function.

If these individuals are eventually determined to be Medicaid eligible, FFP could be claimed.

- **Case Review; LTC Needs and Supporting Resources Assessment; Benefits Counseling; and LTC Options Counseling** – ADRCs will need to conduct time studies for any of these services that the Medicaid agency does not consider to be part of the Medicaid eligibility determination process (see earlier discussion on this issue). These time studies will need to differentiate between Medicaid eligible versus non-Medicaid eligible reviews.

  If these services are classified as part of the Medicaid eligibility determination process in all cases, it may only be necessary to conduct a time study if the individual conducting the case review and/or assessments does other activities that are non Medicaid related.

  Federal regulations allow the ADRC to use samples for the time study rather than capturing this information for all individuals served. These regulations require that this sampling occur on a monthly basis at a minimum. CMS may be willing to accept the use of an alternative methodology, such as calculating the average amount of time for each unit of service provided and developing assumptions regarding the percentage of individuals served who are Medicaid eligible or (when making the case for enhanced match) require a medical review. Any alternative methodology would have to be approved by both the single state Medicaid agency and CMS.

- **Linkage to LTC Services** – Because an ADRC will only be eligible for FFP when this service is provided to an individual who is Medicaid eligible, the ADRC will need to conduct a time study for staff that serve both Medicaid eligible and non-Medicaid eligible individuals or perform other non-Medicaid related services.

- **Interaction with Medicaid Eligibility Approval Process –** Because this task should always be eligible for FFP, time studies will likely only be necessary if the staff performing this function perform other tasks that are non Medicaid related.

- **Assistance in continuous improvement projects for the LTC system** – ADRCs will likely need to conduct time studies for staff engaged in these activities. The ADRC will also need to track these activities and provide a description of if and why they consider staff to be Medicaid eligible.

ADRCs may wish to consider trying to obtain FFP using the optional Medicaid state plan service known as Targeted Case Management (TCM). A CMS State Medicaid Director Letter describes TCM as including the following services: "(1) assessment of the eligible individual to determine service needs, (2) development of a specific care plan, (3) referral and related activities to help the individual obtain needed services, and (4) monitoring and follow-up."[17]

---

[17] State Medicaid Director Letter dated January 19, 2001 available at: http://www.cms.hhs.gov/states/letters/smd119c1.asp.

A state could potentially establish a TCM program that targets Medicaid eligible individuals seeking access to long-term care. Thus, those individuals who enter the ADRC and who are eventually determined to be Medicaid eligible would qualify for the service. The TCM service would then consist of the following ADRC functions:

- Information and Referral;
- Short Term Stabilization;
- Case Review;
- LTC Needs and Supporting Resources Assessment;
- Benefits Counseling;
- LTC Options Counseling;
- Linkage to LTC Services; and
- Interaction with Medicaid Eligibility Approval Process.

The amount of FFP available using TCM rather than administrative dollars could be higher because FFP would be based on the Federal Medical Assistance Percentage (FMAP) for services provided in the state in which the ADRC operates. In 2005, these FMAP rates range from a minimum of 50% to a high of 77.08%.

A TCM program, as with a Medicaid state plan service, would have to be approved and monitored by the designated state Medicaid agency and approved by CMS. Infrastructure necessary for operating a TCM program will vary depending upon how the program is set up. The infrastructure will need to be consistent with the reimbursement methodology established for the program. For example, if the TCM rate is based on actual costs accrued, the ADRC would likely need to establish mechanisms for tracking and reporting these costs. The ADRC will need to work closely with the designated state Medicaid agency in building these systems.

Two areas of concern in developing a TCM as a mechanism for funding ADRC operation are as follows:

1. The TCM program will have to have a target criterion that is broad enough to include most of the individuals eligible for ADRC services, but narrow enough to prevent use by individuals outside of the ADRC. A definition that targets Medicaid eligible individuals seeking long term care services, but not currently receiving services from a 1915(c) HCBS waiver or an institution may suffice.
2. Because TCM is a Medicaid state plan service, any willing provider who meets the criteria for the service must be allowed to participate. States may be able to set provider criteria that the ADRC is likely to meet, but that would be prohibitive to other potential providers. These criteria could include requirements such as the following:
   - Utilize nurses and social workers on staff;
   - Be capable of delivering services 24 hours a day, seven days a week; and

- Have a database of all available long term care providers including their capacity to serve new clients.

When and How to Secure Federal Approval

If the ADRC is expecting to receive enhanced match or if the entire amount of the effort (both state funds and FFP) is expected to exceed $5 million, the state must receive approval of an Advance Planning Document (APD). This document must be filed by the state Medicaid agency with CMS, though the Medicaid agency could require that the ADRC prepare the material for submission.

The Administration for Children and Families, Office of Child Support Enforcement in the Department of Health and Human Services in collaboration with CMS, developed guidance materials for producing an APD. These materials are available at http://www.acf.hhs.gov/programs/cse/stsys/tab6.htm. The following is selected text from that website that provides additional background on APDs:

> *States seeking Federal funding for an information systems development and implementation project must submit an Advance Planning Document (APD) for approval by the Department of Health and Human Services (HHS), if the project funding exceeds the regulatory thresholds specified at 45 CFR 95.611. Federal regulations at 45 CFR 307.10(a) specify that a CSES must be planned, designed, developed, installed or enhanced in accordance with an initial and annually updated APD approved under 45 CFR 307.15.*
>
> *Once a project has been funded at the enhanced FFP rate, it remains an enhanced project and is subject to the enhanced rate thresholds, regardless of the FFP rate that is being requested for a contract, contract amendment or task order.*
>
> *An APD provides the Federal government with information necessary to determine funding levels as well as monitor the progress of a project. It includes a statement of needs and objectives, a requirements analysis, a proposed schedule and budget, as well as other information as described in 45 CFR 95.605 and 45 CFR 307.15. The APD remains the sole vehicle for approval of a project or for approval of FFP for that project. The APD must be complete and submitted according to requirements.*
>
> *There are two major types of APD submissions:*
>
> - *Planning APD, which is used by States seeking reimbursement for the costs of planning for the implementation of a system; and*
> - *Implementation APD, which is used by States seeking reimbursement for the costs of designing, developing and implementing a system.*

In addition, there are two types of APD Updates (APDUs), which are used to keep HHS informed of the project status, and to obtain continued funding throughout the life of the project:

- *Annual APDUs, which are used for providing the official project status reports and requesting continued project funding; and*
- *As-Needed APDUs, which are used if significant changes occur in the project approach, procurement, methodology, schedule or costs.*

Below are selected examples of APDs that could be adapted:

- This link provides a APD template for building immunization registries as a component of the Medicaid Management Information System (MMIS): http://www.cms.hhs.gov/states/letters/smd70600.pdf
- This document describes requirements for developing APDs to fund activities related to HIPAA: http://www.dhs.state.ri.us/dhs/hipaa/documents/APD%20Guide.doc.

Integration with Other Federal Funds

It may be possible to fund portions of the ADRC operations using funds from other federal sources, such as the Older Americans Act (OAA) or Social Services Block Grants (SSBG). As noted in the previous section, it is not allowable to draw Medicaid FFP using federal funds for the state match. Therefore, the ADRC will likely want to craft its operations so that it utilizes these funds to first serve individuals and functions not eligible for Medicaid FFP. Below we provide a brief discussion of the utility of various sources for funding ADRC operations.

Older Americans Act – Older Americans Act (OAA) funds can be used to pay many core ADRC services, such as information and assistance, outreach, benefits counseling, and case management. In addition, the core mission of the National Family Caregiver Support Program can be seen as a parallel effort to that of the ADRC in which the primary target is the caregiver rather than the individual with the disability of long term illness.

Coordination between OAA and ADRC funds could take one of the following formats:

- OAA/National Family Caregiver Support can operate separately from the ADRC with no coordination. This will likely result in duplicated systems and databases and two sources for I&R for caregivers.
- OAA/National Family Caregiver Support can be operated as a separate program from the ADRC, but pool resources for developing core infrastructure, such as the development and maintenance of databases of providers and mutual referrals. This will reduce duplication. The two entities should make efforts to minimize confusion among caregivers regarding where they should go to receive I&R and other services that are offered by both programs.

- OAA funding for I&R, outreach, benefits counseling, and case management, possibly including National Family Caregiver Support funds can be combined with ADRC funds to operate an expanded ADRC. If necessary, the ADRC would expand its core mission to provide these services to caregivers, as well as individuals with disabilities.[18] The ADRC would then want to ensure that the OAA funds are used only to fund services for which it is not planning on obtaining FFP.[19]

Social Services Block Grants (SSBG). Each state is given a capped dollar amount under the Social Services Block Grant (SSBG) program. After declining from $2.3 billion in 1998, the total amount allocated for these grants has been $1.7 billion a year from 2002 to 2004. States have substantial flexibility regarding which populations benefit from these funds and how they are used. The largest portions of these funds are used for child protective services and child foster care.[20]

SSBG guidelines define 29 service categories including an "other" category. These definitions are fairly broad and provide considerable flexibility. Core ADRC functions could possibly fall within one or more of the following categories:

- Case Management
- Counseling Services
- Education/Training
- Health Related Services
- Home-Based Services
- Independent/Transitional Living
- Information and Referral
- Legal Services
- Special Services – Disabled

While the ADRC goals are likely to meet SSBG requirements, the limited pool of these funds is likely to result in stringent competition within each state for these funds. Each state uses its own methodology for dividing these funds. A list of the state officials responsible for overseeing this allocation can be found at the following website: http://www.acf.hhs.gov/programs/ocs/ssbg/docs/stoff.htm.

Integration with other entities supporting employment among individuals with disabilities. There are a variety of initiatives designed to support employment for individuals with disabilities. These initiatives might intersect with the ADRC in the following ways:

---

[18] Because it may be difficult to separate out the needs of the individual from the needs of the caregiver, it is likely that the ADRC would provide services to caregivers even without combining the two programs.

[19] See the section on securing FFP for more information regarding cost allocation plans and time studies. The same infrastructure necessary to justify FFP should be sufficient to allocate sources of funding to OAA funds.

[20] "SSBG 2002: Helping States Serve the Needs of America's Families, Adults and Children," publication of the US Administration for Children and Families, DHHS, http://www.acf.hhs.gov/programs/ocs/ssbg/annrpt/2002/index.html.

1) The ADRC might form a collaborative relationship with the organization operating the employment effort. This relationship may involve mutual referrals and collaborative development and maintenance of core program elements, such as lists of providers.
2) The ADRC may apply for funds and expand its mission so that it becomes a central point for I&R and intake to employment supports as well as long-term care services.

Initiatives that provide I&R, assessment and counseling services regarding employment for individuals with disabilities include the following:

- ***Vocational Rehabilitation*** – The Rehabilitation Act of 1973 provides funds to each state to provide a range of services and job training to individuals with disabilities who would like to be employed. More information about this program can be found at: http://www.ed.gov/programs/rsabvrs/index.html. These services are provided through each state's vocational rehabilitation office. Areas for collaboration could include mutual referrals and assistance in developing and maintaining databases of providers, especially for assistive technology.
- ***One-Stop Career Centers*** – The Department of Labor (DoL), Division of Disability and Workforce Programs (DDWP) manages a variety of grants to support employment among individuals with disabilities. The purpose of these grants is to improve the ability of the One-Stop Career Centers (http://www.careeronestop.org) to serve individuals with disabilities. An ADRC could form a partnership with a local One-Stop to help implement an existing grant or apply for a new grant. More information about these programs can be found at: http://www.doleta.gov/disability/eta_default.cfm. Local One-Stops can be found at: http://www.servicelocator.org.
- ***Benefit Planning Assistance and Outreach*** – The Social Security Administration funds the Benefit Planning Assistance and Outreach (BPAO) program. These funds were awarded to 116 organizations nationwide to assist individuals with disabilities in learning about work incentives and help them plan to obtain or maintain employment. These organizations are required to conduct outreach and coordinate with other agencies providing services to individuals with disabilities (e.g., ADRCs). ADRCs could form relationships with BPAOs to share referrals. In addition, because the BPAOs receive substantial training in disability benefits, the ADRCs could utilize the BPAO to fulfill the benefits counseling function. Information about the BPAO program can be found at: http://www.ssa.gov/work/ResourcesToolkit/congrant.html. A list of state contacts can be found at: http://www.ssa.gov/work/ServiceProviders/BPAODirectory.html.

Cost Sharing and Voluntary Contributions

ADRCs may have the ability to receive contributions from clients for the services received through the ADRC. It is important to make a distinction between receiving voluntary *consumer contributions* and requiring that consumers pay for a portion of their share, or mandatory *cost sharing*. Generally speaking, ADRCs will have much less ability to apply mandatory cost sharing due to federal regulations than requesting voluntary consumer contributions. In addition, it may be necessary to develop more extensive operational infrastructure to implement a mandatory rather than voluntary system.

While cost sharing may help offset some of the ADRC's operating costs, each ADRC will need to consider the following before implementing this requirement:

- Cost sharing is often used as a mechanism to limit or control use of a particular service. Therefore, a cost sharing requirement may have an unintended effect of acting as a barrier to individuals using the ADRC. However, in some cases, ADRCs may want to limit use by certain individuals under certain circumstances. Note that cost sharing cannot be applied when drawing down Medicaid FFP. See discussion below.

- Voluntary contribution, as opposed to mandatory cost sharing, will be less likely to act as a barrier to individuals receiving services. Some have argued that applying a voluntary sliding scale to the receipt of services may actually result in these services being more palatable to individuals because it may allow them to feel less like welfare beneficiaries and more like paying customers.

- Medicaid limitations: Although CMS allows cost sharing to be used for Medicaid services, this is a decision that must be approved by the state Medicaid agency, and must be reflected in its approved state Medicaid plan. In addition:

    - There can be no cost sharing for Medicaid administrative activities.

    - When furnishing a Medicaid-covered service, the provider is required to accept Medicaid's payment plus any *State Medicaid Agency* mandated deductible, coinsurance, or copayment as payment in full.[21]

    - If the ADRC were to provide Medicaid services under a 1915(c) Medicaid Home and Community-Based Waiver, it could apply mandatory cost sharing to these services if this were incorporated into the waiver and approved by the state Medicaid agency. Again, the ADRC would not be able to use cost sharing funds as match for drawing down FFP.

- AoA limitations: Under the Older Americans Act (OAA), a state is not permitted to implement mandatory cost sharing for the following programs funded fully or in part by the OAA (however, receiving voluntary consumer contributions is not prohibited):

    - Information and assistance, outreach, benefits counseling, case management services

    - Ombudsman, elder abuse prevention, legal assistance, other consumer protection services

    - Congregate and home delivered meals

    - Services delivered through tribal organizations

---

[21] 42 CFR 447.21 provides for penalties imposed on providers who seek to collect from an individual (or any financially responsible relative or representative of that individual) an amount that exceeds the payment level established by the Medicaid agency up to three times the amount collected.

These limitations essentially preclude applying mandatory cost sharing to the essential ADRC functions for any individual who is age 60 or older if the ADRC is receiving OAA funds for these purposes. However, there are two conditions under which an ADRC may apply mandatory cost sharing to older adults:

- If the ADRC is not receiving any OAA dollars for these functions, it is not subject to these restrictions. To achieve this, the ADRC may be able to set up a separate organization. Each program must be completely independent of the other with separate accounting, staffing (though one staff person may work part-time with each of the programs), marketing, etc. For example, one of the programs provides services funded with OAA dollars. The other program could then contract with local businesses or receive private pay funds to provide I&R/A, outreach, case management or other services to their employee caregivers or retirees on a cost share basis.

- The ADRC may implement mandatory cost sharing for long-term care services (services other than those listed earlier) it provides and for which it received OAA funds, such as home care, adult day services, respite care, health promotion/disease prevention, transportation and others. Clients unable to pay the cost share must be provided the service.

However, the ADRC may solicit voluntary contributions for all OAA funded services provided the method of solicitation is non-coercive and services are not denied to individuals who do not contribute. AoA has issued the following guidance regarding obtaining contributions from consumers:

> *(1) IN GENERAL- Voluntary contributions shall be allowed and may be solicited for all services for which funds are received under this Act provided that the method of solicitation is noncoercive.*
>
> *(2) LOCAL DECISION- The area agency on aging shall consult with the relevant service providers and older individuals in agency's planning and service area in a State to determine the best method for accepting voluntary contributions under this subsection.*
>
> *(3) PROHIBITED ACTS- The area agency on aging and service providers shall not means test for any service for which contributions are accepted or deny services to any individual who does not contribute to the cost of the service.*
>
> *(4) REQUIRED ACTS- The area agency on aging shall ensure that each service provider will--*
>
> > *(A) provide each recipient with an opportunity to voluntarily contribute to the cost of the service;*
> >
> > *(B) clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;*

> *(C) protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution;*
>
> *(D) establish appropriate procedures to safeguard and account for all contributions; and*
>
> *(E) use all collected contributions to expand the service for which the contributions were given."*[22]

In addition, current Medicaid regulations do not preclude an ADRC from soliciting voluntary contributions from Medicaid eligible individuals. However, if the ADRC chooses to go this route, it should be very careful to emphasize that the refusal to make a contribution in no way limits the ability to receive a Medicaid service for which the individual is eligible. Doing so would be illegal under the Social Security Act and subject to hefty fines. Thus, if an ADRC chooses to go this route, it should be very careful to emphasize this point in any training or other materials because if any ADRC staff member is in violation, the ADRC could be sanctioned.

In summary, cost sharing can be used in the following circumstances:

- For basic ADRC services that are not connected with performing Medicaid administrative tasks, or furnishing Medicaid services (including home and community-based waiver services and case management) (i.e., I&R, assessment, counseling and case management), cost sharing is feasible if:
  - The recipients are below age 60 and are not Medicaid eligible;
  - The entity providing the services is not receiving OAA funds; or
  - Cost sharing is done on a voluntary basis and the ADRC is careful to establish infrastructure and training that is consistent with the federal regulations listed above.
- For other services, cost sharing can be implemented as long as these services are not Medicaid services. Only the state Medicaid agency can impose cost sharing requirements for Medicaid services.
- There can be no cost sharing for Medicaid administrative tasks.

In addition to the issues discussed above, in deciding whether to implement mandatory cost sharing and/or voluntary consumer contributions[23], the ADRCs should also consider the types of infrastructure necessary for implementation. In general, organizations that have implemented mandatory cost sharing have done so using one of the two following mechanisms:

---

[22] Older Americans Act, Section 315

[23] Again, the designated state Medicaid agency would have to approve any mandatory cost sharing requirement that relates to Medicaid funds.

1. Some organizations have established billing and accounts receivable systems to track consumer cost sharing. These systems track services provided to each individual and cost share amounts. The agency then bills consumers and tracks payments provided to them. If the agency collects most of the cost share at the time of service, it would still need a mechanism to track collections by recipient to ensure that the cost share amounts were collected and accounted.

2. Some organizations that subcontract with providers to deliver services deduct the cost share amount from their payment to those providers. It is then the providers' responsibility to collect the cost share.

ADRCs establishing mandatory cost sharing will probably want to establish an accounts receivables system.

If the ADRC chooses to implement a voluntary consumer contribution system, it may not need to establish an accounts receivables system. A system for collecting these contributions should include the following:

- Recommended contribution amounts for each ADRC service. The ADRC will likely want to establish a sliding scale for these contributions. ***Exhibit 12*** provides examples of a cost sharing schedule used by North Carolina and Ohio for Older Americans Act services.

- Guidelines and training for soliciting the contributions.

- A method of receiving the contributions and ensuring that the funds are used to cover the operating costs of the program.

Exhibit 12: Examples of Sliding Scales for Consumer Contributions
North Carolina - 2004

Monthly Income of:			
Individual	Couple	% of Federal Poverty Level	Suggested
Cost-sharing %			
$1,164 - 1,326	$1,561 - 1,778	150% - 170%	30%
$1,327 - 1,489	$1,779 – 1,997	171% - 191%	40%
$1,490 – 1,652	$1,998– 2,215	192% - 212%	50%
$1,653 – 1,815	$2,216 – 2,434	213% - 233%	60%
$1,816 – 1,978	$2,435 – 2,652	234% - 254%	75%
$1,979 – above	$2,653 – above	255% and above	100%

Ohio - 2004

% of Federal Poverty Level	Cost-sharing %
150% - 175%	10%
176% - 200%	20%
201% - 225%	30%
226% - 250%	40%
251% - 300%	50%
301% - 325%	60%
326% - 350%	70%
351% - 375%	80%
376% - 400%	90%
401% and above	100%

Note: The North Carolina amounts are based on percentages of the federal poverty level and updated on an annual basis. North Carolina is considering lowering the minimum income for which it will solicit contributions. For more information about this issue see the *Status Report on Cost-Sharing Policy Revisions* from the NC Department of Health and Human Services, Division of Aging.

Source: North Carolina Division of Aging, http://www.dhhs.state.nc.us/aging/arms/csupdat2.htm and Marcus Molea, AICP, Chief, Planning, Development and Evaluation, Division Ohio Department of Aging.

Organizations that have engaged in soliciting voluntary consumer contributions emphasize the concern between balancing an aggressive effort to solicit contributions against having individuals feeling coerced to give money. These organizations emphasize that a successful effort needs to communicate the importance of consumer contributions not only to the consumers themselves, but the program staff that will be requesting these contributions.

The North Carolina Division of Aging and Adult Services has developed a policy manual regarding consumer contributions. This manual includes two tools that may be helpful to

ADRCs planning on implementing cost sharing: (1) a sample solicitation letter provided to consumers (***Exhibit 13***) and (2) a model group discussion for training staff (***Exhibit 14***).[24]

Exhibit 13: Model Voluntary Consumer Contribution Letter

Dear ___________________________,

We hope you are benefiting from the _______________________ service(s) you are receiving. The money that pays for this service is a combination of federal, state and county funds, plus consumer contributions from other service recipients, like you.

We would like to be able to expand the availability of this service to as many people as possible. We receive a set amount of public dollars each year for this service. The only way we can expand the service is through voluntary consumer contributions. Last year, we were able to serve __________ additional people from contributions.

Therefore, we are asking you to consider making a voluntary contribution toward the cost of the service you receive. This money would be used to serve someone like you. Any amount you can afford will be welcomed.

We also realize that not all people can afford to contribute, and that an individual's financial situation can change. **You are under no obligation to contribute; it is entirely voluntary. Your continued receipt of this service is not dependent on your willingness to contribute.**

If you would like to make a contribution toward the cost of your service, please: (possible options)

1. Contact _______________ at 000-0000 to arrange how you would like to make your contribution.
2. Mail a check (monthly, if possible) made out to __________________________ and address it to: ____.
3. Use the self-addressed envelope provided by our agency to mail your contribution.
4. You may take your contribution in an envelope to ___________________ (agency) and put it in the contribution box.

Our agency, _______________________, will keep an accurate accounting of the contributions you have made, but you need to know they are not tax deductible, since you are receiving service. The amount that you contribute, or do not contribute, will remain confidential.

Thank you for considering making a voluntary contribution, whatever your decision. We look forward to continuing to serve you.

Sincerely,

Source: North Carolina Division on Aging and Adult Services

[24] ***Exhibits 13 and 14*** were slightly altered to remove any references to services or costs particular to a particular individual to avoid any privacy concerns.

Exhibit 14: Model Discussion for Training Staff about Soliciting Consumer Contributions

This method of sharing information about voluntary contributions is particularly applicable for recipients of Congregate Nutrition, but may also work well for recipients/family of Adult Day Services when they are meeting at the center, or any other natural group of persons receiving services.

The presenter (services director or program administrator) can plan to have this discussion at regular intervals (e.g., quarterly) or when there are a significant number of new participants/service recipients. It can be part of a planned program, or brought up at any time that is convenient for recipients and staff. It will be important to strongly emphasize that the contributions are voluntary and not tied to the provision of services so that the individual seeking these contributions does not violate federal laws.

Components of Discussion:

1. Why we need to discuss voluntary Consumer Contributions

   We would like to be able to expand the availability of this service to as many people as possible. We receive a set amount of public dollars each year for this service. The only way we can expand the service is through voluntary consumer contributions. Last year we were able to serve ____ additional clients due to generous contributions.

2. Where the money comes from for the service received

   The money that pays for this service is a combination of federal, state and county funds, plus voluntary contributions from other service recipients, like you.

3. Request for contributions

   We hope you are benefiting from the services you are receiving. If you are, we are asking you to consider making a voluntary contribution. This money would be used to serve someone like you. Any amount you can afford will be greatly appreciated.

4. Why it is important that contributions be voluntary?

   We also realize that not all people can afford to contribute, and that an individual's financial situation can change. **You are under no obligation to contribute; it is entirely voluntary. Your continued receipt of this service is not dependent on your willingness to contribute**.

5. Method(s) for making contributions

   A.

   B.

6. Agency accounting for contributions; confidentiality; where the money goes
   Our agency, _______________________, will keep an accurate record of the contributions you have made (individually, if identifiable, and as a group), but you need to know they are not tax deductible, since you are receiving a service. The amount that you contribute, or do not contribute, will remain confidential. Any contributions received will be used to expand the service to additional persons.

7. Questions/discussion from participants/recipients

The experience of other states may provide guidance to ADRCs considering cost sharing or voluntary consumer contributions regarding how much revenue it is likely to generate. For example, cost sharing and consumer contributions covered almost 5% of the NC Division on Aging and Adult Services' (formerly the Division on Aging) operating costs in 2001-2002 and almost 15% of the program costs for the MI Office of Services to the Aging in 2003. However, as ***Exhibit 15*** and ***Exhibit 16*** point out, these States' experience with voluntary contributions for core ADRC services (i.e., information and referral and case management) generated very little funds (see highlighted rows). This supposition is supported by the results a 2003 review in Ohio that recommended against applying cost sharing to health assessments.[25]

It may be inherently more difficult to solicit voluntary contributions for ADRC services. I&R will likely occur via telephone and will require consumers to mail in contributions at a later time. Consumers may be less likely to be inclined to make contributions for functions such as assessments and case management because they may perceive the benefit as being less concrete and tangible or be less accustomed to paying for the service, in contrast with receiving a meal or a health related service, such as personal care.

In summary, implementing mandatory cost sharing faces significant federal limitations and the necessity of developing an operating infrastructure that the ADRC would want to decide if it is justified by the income generated. On the other hand, soliciting voluntary consumer contributions may produce modest amounts of revenue, enhance personal responsibility and may result in consumers feeling more positive about receiving services.

---

[25] E-mail from Marcus Molea, AICP, Chief, Planning, Development and Evaluation, Division Ohio Department of Aging.

Exhibit 15: Cost Sharing and Total Expenditures SFY 2001-2002 for NC Division on Aging and Adult Services

Service	Expenditures	Cost sharing	% of Exp.
Adult Day Care	$1,516,434	$58,907	3.9%
Adult Day Health	$1,242,770	$22,351	1.8%
Care Management	$975,503	$5,529	0.6%
Congregate Nutrition	$7,683,882	$1,054,959	13.7%
Family Caregiver Support	$2,727,147	$3,163	0.1%
Group Respite	$93,636	$2,676	2.9%
Health Promotion	$478,283	$1,473	0.3%
Health Screening	$26,966	$635	2.4%
Home Delivered Meals	$7,902,231	$752,911	9.5%
Home Health	$30,500	$550	1.8%
Housing & Home Imp.	$714,980	$6,269	0.9%
In Home Aide Level 1	$5,070,359	$101,741	2.0%
In Home Aide Level 2	$8,738,044	$160,818	1.8%
In Home Aide Level 3	$2,921,983	$59,455	2.0%
In Home Aide Level 4	$11,207		0.0%
Information & Assistance	$1,703,182	$540	0.0%
Institutional Respite	$203,186	$5,251	2.6%
Legal	$369,499	$7,736	2.1%
Medication Management	$148,674		0.0%
Senior Center	$3,464,988	$11,251	0.3%
Senior Companion	$124,660		0.0%
Transportation, General	$5,077,762	$123,023	2.4%
Transportation, Medical	$938,651	$23,854	2.5%
Volunteer Program Dev.	$175,466		0.0%
Totals	$52,339,993	$2,403,092	4.6%

Source: *Status Report on Cost-Sharing Policy Revisions* from the NC Department of Health and Human Services, Division of Aging.

Exhibit 16: Cost Sharing and Total Expenditures in for MI AAAs

Service Category	Expenditures	Cost Sharing	% of Expenditures
Care Management	$8,166,342	$23,282	0.3%
Case Coordination & Support	$1,853,718	$51,895	2.8%
Assisted Transportation	$196,010	$28,566	14.6%
Transportation	$1,062,749	$126,448	11.9%
Information & Referral	$1,989,494	$1,311	0.1%
Outreach	$1,515,670	$5,119	0.3%
Personal Care	$5,439,069	$493,312	9.1%
Homemaker	$5,686,989	$587,903	10.3%
Chore Service	$889,224	$122,342	13.8%
Home Health Aide	$41,808	$110	0.3%
Home Injury Control	$199,176	$13,191	6.6%
Medication Management	$248,040	$0	0.0%
Congregate Meals	$16,647,148	$6,546,260	39.3%
Nutrition Counseling	$279,541	$0	0.0%
Nutrition Education	$27,698	$0	0.0%
USDA Nutrition	$6,985,302	$0	0.0%
Home Delivered Meals	$27,896,587	$5,586,545	20.0%
Legal Assistance	$1,028,222	$114,380	11.1%
State Nursing Home Ombs	$535,506	$3,151	0.6%
Elder Abuse Prevention	$247,697	$364	0.1%
Vision Services	$156,694	$1,280	0.8%
Health Screening	$212,004	$575	0.3%
Asst to Hearing Impaired	$118,900	$672	0.6%
Education	$122,741	$582	0.5%
Guardian	$5,976	$0	0.0%
Physical Fitness	$62,082	$5,941	9.6%
Home Repair	$150,265	$10,307	6.9%
Counseling	$1,252,796	$27,455	2.2%
Friendly Reassurance	$26,765	$135	0.5%
Per Emergency Response	$18,153	$160	0.9%
Senior Center Staffing	$2,488,211	$40,382	1.6%
Senior Center Operations	$54,590	$0	0.0%
Disease Prevt/Health Prom	$418,546	$57,455	13.7%
Program Development	$2,094,950	$5,458	0.3%
Special Needs	$36,686	$0	0.0%
Ombudsman	$133,159	$374	0.3%
Title III - Other	$59,493	$125	0.2%
AAA Regional Services (Non-Title III-E)	$343,173	$18,968	5.5%
Caregiver Support (Counseling	$561,710	$16,691	3.0%
AAA Regional Services (Title III-E)	$814,241	$19,599	2.4%
Adult Day Care	$5,217,579	$906,736	17.4%
Respite	$5,878,079	$167,614	2.9%
Specialized Respite	$339,818	$0	0.0%
Totals	**$102,550,563**	**$14,984,688**	14.6%

Source: Hollice Spencer, Director, Community Services Division, Michigan, Office of Services to the Aging.

In addition to the policies developed by North Carolina, examples of other states' cost sharing and/or consumer contribution policies can be found on the following websites:

- Pennsylvania Department on Aging: http://www.aging.state.pa.us/aging/lib/aging/03-01-03_OPTIONS_Cost_Sharing.doc
- Virginia Department for the Aging: http://www.aging.state.va.us/serviceprograms/Cost%20Sharing-Fee%20for%20Service%20State%20Policy.pdf
- Arizona Department of Economic Security, Aging and Adult Administration: http://www.de.state.az.us/aaa/pdf/ch2000.pdf
- Michigan Office of Services to the Aging http://www.miseniors.net/MiSeniors+Home/

Private Donations and Grants

An ADRC may want to seek to cover some of its operating costs with donations from individuals or organizations or by seeking grants from foundations. In regards to these funding sources, the ADRC will want to consider: (1) whether these funds can be used as match to draw down FFP and (2) whether these donations are tax deductible. Only public funds may be used as the State's match to draw down FFP. ADRCs that are not public agencies may not provide the State's match. ADRCs that are public agencies may provide the State's match, provided that the conditions in 42 CFR 433 Subpart B are met.

Federal grants cannot be used as state match for drawing down FFP. However, non-federal grants could be used as match if these grants do not come from a provider.

If the ADRC is operated by a 501(3)(c) nonprofit organization or a government agency, these donations could be tax deductible. For more information, see IRS publication #526 which provides guidelines on charitable deductions (http://www.irs.gov/pub/irs-pdf/p526.pdf).

Marketing Spin-off Services/ Partnerships

Selling Subscriptions to Databases. In order to fulfill the I&R function and to provide individuals with information about the availability of providers, each ADRC will need to develop and maintain a database of available providers of long-term care in the area it serves. These databases may be of value to other organizations, such as hospitals or employer assistance programs. The ADRC could potentially sell access or subscriptions to these databases. Note that in no case may the ADRC's database of clients be sold.

For example, the AAA in Atlanta, Georgia sells an annual subscription to a statewide database of providers of long-term care services. The Atlanta AAA coordinates the efforts of AAAs across Georgia in gathering, validating, and entering the information into a Microsoft Access based database. This database has information on approximately 12,000 providers. They then sell subscriptions to the database to hospitals, HMOs, social service agencies, housing facilities, a nursing facility, and private service coordination agency. They also sell the database to the

State's Department of Human Resources, which utilizes the database to support the operations for the following programs: adult protective services, mental health, developmental disabilities, addictive diseases, and aging services. The price for a subscription for a private business that serves all income groups is $7,500. If the agency's mission statement is to serve low income individuals, the fee is reduced to $3,000 per year. These subscriptions generate approximately $150,000 per year. For additional information, please contact Cathie Berger (404-463-3235/ cberger@atlantaregional.com).

Private pay case management. An ADRC may consider private pay case management as an auxiliary income source. Because of the ADRC's position as the central point of access for long-term care services, it may be possible to either offer private pay case management services or to charge other case management agencies that get referrals from the ADRC. However, the ADRC may not charge other agencies for referring Medicaid-eligible individuals to receive Medicaid-funded services. Additional information about geriatric case management can be located at: http://www.caremanager.org/index.cfm. In addition, examples of two AAAs that offer private case management are provided below:

- AAA in Richmond, Indiana, hourly rate of $36, website at: http://www.iue.edu/Departments/Area9/Private%20Pay.htm

- AAA in Franklin County, Massachusetts, hourly rate of $80, website at: http://www.fchcc.org/privpay.html

Charges for Referrals. The ADRC could develop preferred provider relationships with providers. These providers would pay a fee to have their organizations listed more prominently in lists of potential providers given to individuals accessing the ADRC. This model is similar to that used by the search engine Google (http://www.google.com/ads). In this model, while Google still provides an unbiased internet search, it also prominently displays links to companies that have paid a fee. Any ADRC considering developing these relationships should fully disclose which providers have paid for better placement. Again, under no circumstances may the ADRC charge for referring Medicaid-eligible individuals for Medicaid services.