Attachment G: Medicaid Support for ADRC Functions

Medicaid Federal Financial Participation (FFP) and Federal Medical Assistance Percentage (FMAP) for ADRC Functions

Overview

This document describes how Medicaid funds can be used to support some ADRC functions, such assistance in applying for Medicaid benefits review, service planning and case management for Medicaid beneficiaries. States can receive Federal Financial Participation (FFP) from the federal government for costs associated with the "efficient and effective" administration of the Medicaid program. Generally the Medicaid "administrative match" rate is 50%.[1] States can also claim Federal Medical Assistance Percentage (FMAP) for the costs of providing certain services, such as case management.

While the Medicaid single state agency must administer or supervise the administration of the Medicaid program, that entity can delegate or subcontract many administrative functions. Thus, the State may be able to claim FFP for the cost of administrative functions performed for under an interagency agreement.

In accordance with CMS Medicaid policy, all governmental entities other than the State Medicaid Agency (SMA) performing administrative activities on behalf of the SMA in accordance with an intergovernmental agreement, are required to develop a cost allocation plan that must be approved by the DHHS Division of Cost Allocation and CMS prior to the time the State may claim FFP for costs incurred by those entities for Medicaid administrative activities. Claims for FFP must be supported by certifications by the other entity of the expenditures incurred that are eligible for FFP.

The SMA is not permitted to delegate or subcontract discretionary policy making functions, and retains ultimate authority and responsibility for all functions performed for the administration of the State plan.

In order for activities to be claimed as Medicaid administrative expenditures at the standard 50% FFP rate, the following requirements must be met:

- Costs must be "necessary for the proper and efficient administration of the Medicaid State Plan" (Section 1903(a)(7) of the Social Security Act).
- Costs must be allocated in accordance with the relative benefits received by all programs, not just Medicaid (Office of Management and Budget (OMB) Circular A-

[1] There are higher match rates in some circumstances, such as for compensation and training of skilled professional medical personnel employed by state or local agencies who are performing Medicaid administrative tasks that are medically related (such as utilization reviews).

87). In many situations, this is accomplished by allocating costs by the percentage of Medicaid eligible individuals served, or the percentage of Medicaid covered services furnished.

- Costs must not duplicate costs that have been, or should have been, paid through another source.
- State or local governmental agency costs must be supported by an allocation methodology under the applicable approved public assistance Cost Allocation Plan (42 Code of Federal Regulations (CFR) 433.34).
- Costs must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a provider facility or otherwise include costs of a direct service to beneficiaries (these should be claimed as service costs, not plan administration).
- Costs must not duplicate activities that are already being offered or should be provided by other entities, or through other programs.
- Costs must be supported by adequate source documentation.
- Costs must not be federally-funded or used for any other federal matching purposes.

Functions Potentially Eligible for FFP and FMAP for Medicaid

Outreach and enrollment ADRC functions likely qualify for FFP, while service plan development, service activation, and quality assurance can qualify for either FFP or FMAP. Exhibit A shows the functions that are eligible or potentially eligible for FFP and/or FMAP.

Exhibit A: ADRC Functions Eligible for Medicaid FFP and/or FMAP

Screening/ Personal Interview[2]	1. Screening/Intake for Medicaid or Other Public LTC Programs		
Screening/ Personal Interview[2]	2. Pre-screening for Nursing Home Admission such as medical assessment or case management.		Could be a medical assessment or case management service

[2] These functions are considered outreach.

LTSS Front Door Functions		Medicaid FFP	Medicaid FMAP (for Waiver Services)
Assessment/ Eligibility Determination	Assisting to Complete and/or Submit Financial Eligibility Applications	Yes	
Assessment/ Eligibility Determination	Conducting a review for Level of Care Assessments (HCBS)	Only government agencies (Note that the diagnostic medical part of the assessment is a service; only the review of the medical assessment is administration	Medical assessment is a service
Assessment/ Eligibility Determination	Conducting Level of Care Assessments (NF)	Only government agencies	
Assessment/ Eligibility Determination	Making Financial Eligibility Determinations (ADRC or co-located with ADRC)	Only government agencies	
Assessment/ Eligibility Determination	Making Functional Eligibility Determinations for HCBS (ADRC or co-located with ADRC)	Only government agencies	
Assessment/ Eligibility Determination	Making Functional Eligibility Determinations for NF (ADRC or co-located with ADRC)	Only government agencies	
Service Plan Development/ Activation of Services	Develop Action/Service Plan	*Potentially*	Yes

LTSS Front Door Functions		Medicaid FFP	Medicaid FMAP (for Waiver Services)
Service Plan Development/ Activation of Services	Facilitate program enrollment for publicly funded services	Yes	
Service Plan Development/ Activation of Services	Initiate Services through participant direction	*Potentially*	Yes
Service Plan Development/ Activation of Services	Facilitate and assure service providers have been contacted and establish first date of service	Yes	Yes
Service Plan Development/ Activation of Services	Care Coordination	Potentially	Yes
Service Plan Development/ Activation of Services	Ongoing Participant Direction Support	*Potentially*	Yes
Quality Assurance	Follow-up with individual to assure services are being provided as planned and that services provided meet individual's needs	*Potentially*	Yes
Quality Assurance	Confirm that individual is receiving publicly funded services as planned	Yes	Yes
Quality Assurance	Data reporting system that monitors program performance, customer satisfaction, and customer trends and preferences	*No*	*No*

Note: Potentially is dependent on whether a State has established these functions as eligible under Medicaid through the use of specific waivers or other authorities. Applicants should consult with CMS.

Process for Securing FFP for ADRC Functions

- **Step 1: Determining the Cost/Benefit of Securing Matching Funds.** ADRC programs will need to determine whether the level of effort to establish mechanisms to claim, as well as document Medicaid eligible activity, will yield enough funding to make it worth the effort.

- **Step 2: Engage State Medicaid Agency and Establish MOU.** Governmental agency costs should be included in the applicable cost allocation plan. 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 developing such methodologies, and can provide direction as to how to proceed. An interagency agreement, which describes and defines the relationships between the State Medicaid agency and 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 governmental 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 for Montana and Florida can be found at http://www.adrc-tae.org/tiki-index.php?page=MedicaidFunding

- **Step 3: Determine Expenditure Basis for FFP.** Two strategies exist to request FFP: 1) an administrative contract; or 2) direct reimbursement of costs. The approach depends on the status of the entity or employees who will be conducting the ADRC eligible functions. Some ADRCs will have to utilize both strategies depending on the status of the individuals carrying out the eligible functions. For non-governmental employees, the ADRC can establish a contract with the State Medicaid agency to perform certain administrative activities keeping in mind the States' procurement and contracting processes and regulations. If the ADRC employees work for the State or local government, the State must directly claim on a cost basis. This will require that the state identify eligible public expenditures and certify that they are accurate using documentation, such as time studies or alternative means to allocate costs across all funding sources. Governmental expenditures for which administrative FFP is to be claimed and the methodology for certifying that they are accurate must be included in the applicable State Cost Allocation Plan.

- **Step 4: Establish Documentation Methodology.** Unless staff allocate 100 percent of their time to Medicaid related activities, ADRCs must conduct time studies to develop claims. Federal regulations provide flexibility regarding how time studies can be conducted and allow a state to propose an alternative methodology to conduct a time study. However, tracking 100 percent of staff time spend on Medicaid related activities may be the most comprehensive way to maximize FFP. The designated state Medicaid agency and CMS must approve the methodology and it should be included as part of a state's Cost Allocation Plan. It is also important to remember that FFP can be claimed for outreach and enrollment assistance for individuals whose Medicaid status is unknown

- **Step 5: Submit Certified Public Expenditures and any Claims for Funding from the State Medicaid agency.** Certified public expenditures must be submitted to the State Medicaid agency in accordance with steps 1-3. The agreement with the State Medicaid Agency will specify the amount of funding the State Medicaid agency will provide to ADRCs,

Selected FFP Case Studies

Currently, several states claim FFP for Medicaid eligible services. Exhibit B presents a brief snapshot of the activities for which the state claims and the method used for claiming.

Exhibit B: Examples of States that Currently Claim FFP for ADRC Functions

State (year began claiming)	Activities[3]	Methodology
Florida (2007)	1. Outreach 2. Assisting in application process	Staff 100% dedicated to Medicaid compensable activities.
Montana (2008)	1. Outreach 2. Information and Referral 3. Intake 4. Application assistance	Track 100% time spent on Medicaid related activities through IRIS database. They have a reporting form which calculates total operating costs multiplied by the percentage of Medicaid minutes for the month.
New Mexico (2004)	1. Outreach 2. Information, Referral and Intake 3. Short-term Stabilization 4. Case Review Assistance 5. Long Term Care (LTC) Needs and Supporting Resources Assessment 6. LTC Options Counseling 7. Linkage to LTC and Supportive Services 8. Interaction with Medicaid Eligibility Approval Process 9. Assistance in continuous improvement projects for the LTC system	Track 100% of time in one hour increments the first month of the fiscal year to project the proportion of staff time devoted to Medicaid claimable activities.

[3] The names of the activities come from the interagency agreements and written documentation from the particular state.

State (year began claiming)	Activities[3]	Methodology
Washington (1996)	1. Medicaid outreach 2. Pre-screening for Medicaid programs 3. Facilitating Medicaid application 4. Assisting clients to utilize Medicaid services 5. Interagency coordination for Medicaid services	Daily time studies one month out of every three month period. Months are selected at random by the SUA.
Wisconsin (1999)	1. Outreach and facilitating application. 2. Medical service coordination. 3. Level of Care/Functional screen admin 4. Functional screen – updates, training, quality	Track 100% of time spend on Medicaid and non-Medicaid.

Florida

Florida has claimed FFP for ADRCs since 2007. The ADRC staff began to explore the potential to obtain Medicaid funding for some ADRC functions and approached their State Medicaid Agency – the Agency for Health Care Administration (AHCA). AHCA, Florida's single state Medicaid agency funds a position at the ADRC to determine Medicaid eligibility. They do not have a cost allocation plan (CAP), because its activities are identified as 100% Medicaid – related, hence no need to allocate expenditures among other programs as well. The "State Unit on Aging (SUA)," the Department of Elder Affairs submits invoices to AHCA for payment, in relation to the ARCs and ARDCs.

Montana

Montana has claimed FFP for ADRCs since 2008. The process started when an ADRC in one county was conducting Medicaid enrollment activities and an Office of Public Assistance (Medicaid eligibility) staff member suggested that the ADRC seek FFP. Over the following year, the ADRC worked with The Lewin Group, Montana Department of Public Health & Human Services (DPHHS), which oversees Medicaid, and the CMS Regional Office to develop a draft Memorandum of Understanding (MOU) outlining the scope of eligible

Medicaid related work. The effort culminated in a final MOU and time tracking methodology. Montana claims for the following activities: 1) contact with client or another agency regarding Medicaid eligibility, 2) information and referral regarding Medicaid issues and Medicaid funded services, 3) intake activities, 4) assistance in completing appropriate Medicaid applications, 5) interaction with Medicaid eligibility approval process, and 6) assistance in continuous improvement projects for the Long Term Care system. Montana's SUA tracks all time spent on Medicaid and non-Medicaid related activities and state level reports on all Medicaid administrative activities come from the statewide IRis database which has been modified to collect FFP information as well as ADRC demographic information. The ADRC Medicaid Administrative Funding Request form captures information on monthly site expenditures (including employee salary and benefit expenses, direct supplies, rent and utilities), Medicaid allowable minutes and total minutes (used to calculate the percentage of time spent on claimable activities) and total Medicaid eligible costs (total costs multiplied by the percentage of Medicaid minutes for the month). After receiving the request form, the State Medicaid Agency sends payment directly to the ADRC.

New Mexico

New Mexico has claimed FFP for ADRCs since 2004, when they received their federal ADRC grant. Through an agreement with the State Medicaid Agency (Human Services Department) the New Mexico ADRC conducts a time study the first month of each fiscal year to determine what percent of time they spend on Medicaid related activities. They currently have five ADRC positions funded using match funding. New Mexico claims for the following activities: 1) Outreach, 2) Information, Referral and Intake, 3) Short-term Stabilization, 4) Case Review Assistance, 5) LTC Needs and Supporting Resources Assessment, 6) LTC Options Counseling, 7) Linkage to LTC and Supportive Services, 8) Interaction with Medicaid Eligibility Approval Process, and 9) Assistance in continuous improvement projects for the LTC system. Each ADRC uses 100 percent time tracking in hour increments excel spreadsheet during first full month of fiscal year to document the time spent on Medicaid activities.

Washington

Washington has claimed FFP for ADRCs functions since 1996. At that time, the state legislature made the state operated local home and community services offices the Single Entry Point (SEP) for Medicaid and other supports and services. The SEPs were charged with conducting initial assessments and financial determinations for eligibility. AAAs or subcontractors took over on-going long-term case management for anyone who wanted to remain in their own homes. With this Medicaid State Plan change related to case management, the State was able to extend the information and assistance (I&A) program. In 2006, Washington revised its policy, including the time study process. Washington

claims for the following activities: 1) outreach, 2) pre-screen for Medicaid, 3) facilitating application to Medicaid, 4) assisting to utilize Medicaid services, and 5) interagency coordination for Medicaid services. Each participating Area Agency on Aging uses a time study to capture 100 percent of time worked and incorporate a comprehensive list of activities performed by staff whose costs are to be claimed under Medicaid. The time study reflects all of the time and activities (whether allowable or unallowable under the Medicaid program) performed by employees. Programs complete daily time studies one month out of every three month period. The time study month is chosen randomly by the State Unit on Aging and communicated to all participating AAAs.

Wisconsin

Wisconsin has claimed FFP for ADRCs since 1999. They have always tracked 100% of staff time rather than using a random moment time study, one of the two options they were given by CMS. In 2008, Wisconsin renegotiated its claiming process and CMS approved an updated time allocation methodology. Wisconsin claims for the following activities: 1) medical administrative activity – outreach and eligibility (including Medicaid outreach, facilitating an application for the Medicaid program), 2) medical service coordination (including referral, coordination, and monitoring of medical services, program planning, policy development, and interagency coordination related to medical services), 3) inputting the functional screen, and 4) updates to the functional screen, functional screen training time, and quality monitoring of the screen. Although the 100 percent time tracking methodology is labor intensive, the state feels that the benefits outweigh the costs. Each staff person completes a time log spreadsheet on a daily basis tracking all of his or her activities both Medicaid and non-Medicaid related. The Department of Health Services aggregates the time study data on a monthly basis to determine the amount of time dedicated to Medicaid activities.

Process for Securing FMAP for ADRC Functions

Several states contract with ADRCs to provide case management as a direct service through Medicaid HCBS waivers or it is included as a state plan service. While the FMAP can provide many States a higher federal reimbursement than FFP, reimbursing for case management as a service generally requires choice of providers. As a result, a State may have less control over the case management function. Also, ADRCs should separate administrative functions such as utilization review from the provision of direct services such as competitive case management. This ensures that assessors do not feel pressure to make individuals eligible to increase business, and ensures that case managers are not pressured to restrict the options that they recommend to beneficiaries.

Additional Details Regarding Interagency Agreements for Cost Allocation Plans

Interagency agreements may only exist between governmental (i.e., public) entities and cannot extend to private contractors or consultants. If your ADRC(s) are non-governmental, the State may purchase services from the non-profit rather than using a cost allocation mechanism.

Interagency agreements must be in accordance with State law. That is, States must consider their own civil statutes relative to interagency agreements, and their status as a single State agency for the Medicaid program as defined at 42 CFR 431.10. Consideration must also be given to state contracting requirements. For example, some State laws do not allow interagency agreements to have effective dates prior to the date that all parties to the agreement have signed the agreement.

Elements of the Interagency Agreement

CMS generally expects the interagency agreement to document the scope of the activities being performed by the ADRC and provide a basis for FFP to be claimed. CMS guidance indicates that an interagency agreement includes:

- Mutual objectives of the agreement;
- Responsibilities of all the parties to the agreement;
- Activities or services each party to the agreement offers and under what circumstances;
- Cooperative and collaborative relationships at the state and local levels;
- Specific administrative claiming time study activity codes which have been approved by CMS, by reference or inclusion;
- Specific methodology which has been approved by CMS for computation of the claim, by reference or inclusion;
- Methods for reimbursement, exchange of reports and documentation, and liaison between the parties, including designation of state and local liaison staff.

The interagency agreement should address the Medicaid administrative claiming process, identify the services the State Medicaid agency will provide for the local entity, including any related reimbursement and funding mechanisms, and define oversight and monitoring activities and the responsibilities of all parties. All participation requirements the State Medicaid agency determines to be mandatory for ensuring a valid process should be detailed in the agreement. Maintenance of records, participation in audits, designation of local project coordinators, training timetables and criteria, and submission of fiscal information are all important elements of the interagency agreement. Also, the specific methodology, which may include a standardized claim form, the mechanism for filing the claim, and the approved allocation methodology that may include use of a time study by the local entity, are valid agreement elements.

Although prior approval by CMS of the interagency agreement is not required, State Medicaid agencies are encouraged to consult CMS during the development of their model interagency agreements for Medicaid administrative claiming. CMS has the authority to

review interagency agreements to ensure that activities are in support of the proper and efficient administration of the State plan.

Federal regulations (42 CFR 433.34) require that under the Medicaid State plan, the single state agency have an approved public assistance cost allocation plan (CAP) on file with DHHS that meets certain regulatory requirements (Subpart E of 45 CFR part 95). As indicated in Subpart E of 45 CFR part 95 and referenced in Office of Management Budget (OMB) Circular A-87, Attachment D, a State's public assistance CAP is an official document which describes the procedures that states use in identifying, measuring and allocating State agency costs incurred in support of all programs administered or supervised by the State agency, such as TANF, Medicaid, the Supplemental Nutrition Assistance Program (SNAP – formerly known as Food Stamps), Child Support Enforcement, adoption assistance, and Foster Care and Social Service Block Grant. Other State agencies, and local governmental agencies, may have their own approved cost allocation plans.

There are certain items that must be in the public assistance CAP which a State Medicaid agency must submit before providing FFP for administrative claiming, if it chooses to use outside entities to provide such services. The public assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues pertinent to the allocation of costs and submission of claims. Depending on the nature of the referenced time study and costing methodology, they may have to be amended to comply with documentation requirements.