**OMB Approval No. 0985-0018**
Expiration 08/31/2013

# *Aging and Disability Resource Center Program*

## Funding Opportunity and Grant Application Instructions

## Administration for Community Living
## Centers for Medicare & Medicaid Services
## Veterans Health Administration

## May 31, 2012

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# *Executive Summary*

## *Aging and Disability Resource Center Program Funding Opportunities*

**The ADRC Program Funding Opportunity represents two unique funding opportunities. These funding opportunities include:**

| Funding Section | Funding Source | Total Amount Available | Purpose | Eligible Entities |
|---|---|---|---|---|
| **Part A – The Enhanced ADRC Options Counseling Program** | Sec 2405 | FY12 – Up to $5.6 Million<br>FY13 – Up to $6.4 Million<br>FY14 – Up to $6.4 Million<br>*Total – Up to $18.5 Million* | Developing Integrated ADRC Options Counseling Program | State Governmental Entities designated by the Governor, D.C Mayor |
| **Part B – ADRC Sustainability Program Expansion Supplemental** | Sec 2405 and OAA Title IV | FY12 – Up to $6.9 Million | ADRC Sustainability | Existing FY 2009 ADRC Grantees |

The U.S. Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS) and the Veterans Health Administration (VHA) have created this funding opportunity for states to significantly strengthen and expand their person-centered access programs to help people learn about and access the long term services and supports (LTSS) that best meet their needs

The Affordable Care Act, P.L. 111-148, provided $10 million per year for five years in mandatory appropriations (from FY 2010-FY 2014) for ADRCs. Because grants made under this funding opportunity will be incrementally funded for three years, this funding opportunity represents the last announcement that will be issued from these ACA mandatory ADRC appropriations. Further action by the Congress would be required to provide funding for future years after FY 2014.

**Applicant's Teleconference**

An open information teleconference for applicants of the funding opportunities under this announcement will be held as follows:

- June 12, 2012 at 1PM EST. The toll-free teleconference phone number will

be 1-800-369-3160, pass code: 1683139

**OMB Approval No. 0985-0018**
Expiration 08/31/2013

# *Part A: The Enhanced ADRC Options Counseling Program*

## Funding Opportunity and Grant Application Instructions

## Administration for Community Living
## Centers for Medicare & Medicaid Services
## Veterans Health Administration

**May 31, 2012**

**Department of Health and Human Services (HHS)**

**Administration for Community Living (ACL)**

**ACL Center: Center for Disability and Aging Policy**

**Funding Opportunity Title: The Enhanced ADRC Options Counseling Program**

**Announcement Type: Initial**

**Funding Opportunity Number:** HHS-2012-ACL-RO-1210

**Catalog of Federal Domestic Assistance (CFDA) Number:** 93.517

**Key Dates:** The deadline date for submission of applications is 11:59 p.m., Eastern Time, on July 25, 2012. Applications that fail to meet the application due date will not be reviewed and will receive no further consideration. You are strongly encouraged to submit your application a minimum of 3-5 days prior to the application closing date. In the event you encounter technical difficulties, either on your end or, with ***http://www.grants.gov***. Grants.gov can take up to 48 hours to notify you of a successful submission.

**Applicant's Teleconference**
An open information teleconference for applicants of the funding opportunities under this announcement will be held as follows:

- June 12, 2012 at 1PM EST. The toll-free teleconference phone number will be 1-800-369-3160, pass code: 1683139

| | |
|---|---|
| Total Funding Year 1: | approximately $5,600,000 in FY 2012 |
| Estimated Year 2: | approximately $6,400,000 in FY 2013 |
| Estimated Year 3: | approximately $6,400,000 in FY 2014 |
| Project Period: | 09/30/2012 – 09/29/2015 |
| Budget Periods: | 09/30/2012 – 09/29/2015 |
| Number of awards: | Funding for a total of up to 8 states/territories: |
| Type of grantee: | State Governmental Entities designated by the Governor, D.C Mayor (such as a State Unit on Aging, State Medicaid Agency, State Disability Agency, or other entity of government at the State level) |
| Letter of Intent Due: | June 22, 2012 |
| Type of award: | Cooperative Agreement |
| Type of activity: | Implement and sustain a statewide integrated Aging and Disability Resource Center Options Counseling Program |

**Executive Summary and Vision**

The U.S. Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS) and the Veterans Health Administration (VHA) have created this funding opportunity for states to significantly strengthen and expand their person-centered access programs to help people learn about and access the long term services and supports (LTSS) that best meet their needs. These access programs are currently referred to by various names including Aging and Disability Resource Centers (ADRCs) and No Wrong Door/Single Entry Point (NWD/SEP) Programs and exist to varying degrees of functionality across the nation. For purposes of this funding opportunity, we are using the label "The Enhanced ADRC Options Counseling Program."

Our goal is to fund states with ADRC programs that can serve as high-performing national models for providing LTSS Options Counseling to all State residents with LTSS needs. Additionally, this funding opportunity aligns with states pursuing other health system transformation efforts such as Medicaid Balancing Incentive Program and demonstrations under the Center for Medicare & Medicaid Innovation. The ADRCs funded under this Opportunity will also have access to a special funding opportunity—being made available by the Veterans Health Administration (VHA)—to assist veterans with disabilities and their family caregivers to access VHA-funded home and community-based services.

Finding the right services can be a daunting task for individuals and their family members. The current LTSS system involves numerous funding streams, and is administered by multiple federal, state and local agencies using complex, fragmented, and often duplicative intake, assessment and eligibility processes. There are more and more options for services and supports, in home, residential, and institutional settings. Individuals trying to access the multitude of new LTSS frequently find themselves confronted with a maze of agencies, organizations and bureaucratic requirements at a time when they may be vulnerable or in crisis. These issues frequently lead to use of the most expensive forms of care, including institutional care such as nursing homes or extended hospitalization, and can cause a person to quickly exhaust their own resources.

A high performing ADRC Options Counseling Program is designed specifically to help individuals and their family caregivers access the right services at the right time in the right setting. It will have capacity to serve people of all ages, disabilities and income levels, including individuals interested in planning for or able to pay for their LTSS needs. It will also streamline eligibility determinations for people appropriate for public LTSS programs and increase access to lower cost community-based

alternatives that can help avoid institutional care and preserve personal resources. States will use their ADRC Options Counseling Programs as a key tool for rebalancing their LTSS systems and for making their systems more person-centered, more efficient, and more supportive of community living.

Under this funding opportunity, ADRC Options Counseling Programs will meet the national performance standards and training and certification requirements. These standards and training requirements will be established by the ACL in collaboration with CMS, VHA and the funded states. The funded states are also *required* to adopt the standards established by CMS for the Balancing Incentive Program NWD/SEP structural change. ACL also *strongly encourages* states to adopt a Core Standardized Assessment as outlined in the Balancing Incentive Program structural changes. Funded local ADRC sites will also have formal partnerships with health systems and hospitals to ensure that certified ADRC Options Counselors are included on interdisciplinary care teams to help reduce hospital readmissions. This type of alignment of the health and LTSS systems can improve the ability of a state to transform its health system to a fully integrated model.

As states undergo health system transformation and LTSS rebalancing activities, development of a financially sustainable infrastructure for the ADRC Options Counseling Program model is critical to controlling the growth in public expenditures while also ensuring that citizens have ongoing coordinated access to the LTSS that best meet their needs and preferences. States will use this funding opportunity to develop and implement financially sustainable models that embed ADRC Options Counseling into their statewide LTSS systems. The ADRC Options Counseling Program provides all payers a vehicle for better coordinating assessments, service plans, eligibility determinations, data collection, and reporting for all LTSS populations.

The long-term outcome for successful state applicants will be documented increases in community-living and quality of life for state residents as well as a more effective use of public resources especially as people access lower cost alternatives to institutional care. This will be accomplished by the states over a three year project period by:

1. Strengthening the capacity of the ADRC Options Counseling Program to serve people of all ages, income levels and disabilities by adopting a “No Wrong Door” approach that operationally involves a wide array of community agencies and organizations in the ADRC so it can effectively serve a broad range of populations, including at a minimum, older adults, people with disabilities of all ages, people with physical, intellectual and developmental disabilities (ID/DD), and family caregivers.

2. Rapidly diffusing trained and certified ADRC Options Counselors throughout the funded states, and building stronger partnerships between health and LTSS systems to reduce unnecessary readmissions and promote improved health, better care and lower costs. This includes placing ADRC Options Counselors on interdisciplinary care teams and to linking individuals discharged from institutional settings to community based LTSS.

3. Developing financially sustainable ADRC models that includes revenue from multiple public programs (including Medicaid, Medicare, the Older Americans Act, the VHA and other programs) to cover expenses associated with such tasks as:
    - outreach,
    - screening/assessing individuals' need for LTSS,
    - working with individuals and their families to develop service plans,
    - linking individuals to needed services, helping individuals to use self-directed service models, and
    - assisting individuals in determining their eligibility for public programs.

4. Adopting national performance and outcome standards and aligning data collection and reporting methods across LTSS payers within a state to minimize administrative burden and support continuous quality improvement. The funded states will participate in a 6 month collaborative process with ACL, CMS, and VHA to develop a nationally directed evaluation. This National Evaluation Framework will document the impact of ADRC Options Counseling Programs on the quality of life and well-being of individuals and families, and the utilization and cost of LTSS and health care services.

# I. FUNDING OPPORTUNITY DESCRIPTION – PART A

## 1. Background and Need

The Administration on Aging (now the Administration for Community Living—ACL) and CMS have provided grants to states over the past decade to develop person-centered systems to make it easier for individuals to learn about and access their long-term services and support options. These "one stop shop" programs are known as "Aging and Disability Resource Centers" as well as "No Wrong Door – Single Points of Entry" Programs, and they are designed to serve as visible and trusted sources

where people can access objective information on their long-term services and support options and other benefits including Medicare. These programs also provide one-on-one counseling and advice to ensure that individuals, including private pay individuals, fully understand what options are available to meet their particular needs and preferences. For people who might qualify for a public program, ADRC Options Counseling Programs provide a streamlined eligibility processes leading for all publicly funded long-term services and support programs.

In 2010, ACL awarded funding to 19 states to partner in the development of a set of national standards for the ADRC Options Counseling Program. Options Counseling is an interactive process whereby individuals, family members and/or significant others are supported by a trained counselor in their deliberations to determine appropriate LTSS choices in the context of a person's strengths, preferences, and values. ADRC Options Counseling is available to all persons making long-term support decisions regardless of income or financial assets, including individuals who can pay for supports. Since the 2010 Options Counseling Grants were awarded, ACL has collaborated with 19 grantee states, 65 Area Agencies on Aging (AAAs), 25 Centers for Independent Living (CILs), a variety of national organizations representing aging and disability populations, and our federal partners, to develop national Options Counseling standards. The effort has focused on standardizing the ADRC Options Counseling process so it can be clearly defined, easily monitored, and readily utilized by the states, as well as by private health plans, managed care organizations, and other funders to assist their clients in accessing LTSS. It also incorporates sufficient flexibility to support local diversity and coordination with various federal programs such as the Balancing Incentive Program, Veterans Directed Home and Community Based Services (VD-HCBS), Money Follows the Person (MFP) Demonstration, and other transition support programs.

The national Options Counseling standards are scheduled for completion in the fall of 2012, and the 19 states receiving 2010 grants have already demonstrated tremendous momentum in adopting standard options counseling practices. An additional 21 states are in various stages of planning and development. Many states have developed partnerships with outside organizations for delivering options counseling training. Organizations trained in options counseling to date include senior service networks, CILs, other disability agencies, hospital staff, and community-based nurses and social workers. As a result of this past work, funded states will work with ACL to finalize the national standards and implement a national training and certification program for ADRC Options Counselors.

ADRCs also are developing a capacity to serve as a national platform to provide transition support to individuals and caregivers. Since ACL and CMS first began funding ADRCs in 2003, ADRCs have been required to work with hospitals and nursing care facilities to assist individuals in "critical pathways," which are defined as

the times or places when people make important decisions about long-term care. This work included several initiatives to coordinate with the hospital discharge process and to help nursing facility residents' return to the community. The 2009 Program Announcement for ADRCs identified "person-centered hospital discharge planning" as a key operational component of an ADRC system. In 2010, the ADRC Evidence-Based Care Transitions program was launched to support state efforts to significantly strengthen the role of ADRCs in implementing evidence-based care transition models. ADRCs have served as a resource for acute, primary and related health professionals and provide the healthcare system with a "single entry point" to community-based services and supports. The current funding opportunity will build upon this experience and continue to systematically implement evidence-based care transition models in ADRC programs.

In addition, this funding opportunity requires states to address program sustainability by linking ADRC Options Counseling to Medicaid and VHA rebalancing efforts and CMS supported health systems transformation initiatives. States will develop partnership agreements with the Single State Medicaid Agency for using the ADRC Options Counseling Program to serve as the "No Wrong Door" for individuals who are eligible for, or may be eligible for, Medicaid LTSS, making some of the tasks performed by the ADRC Options Counseling Program eligible for Medicaid reimbursement. The ADRCs funded under this Opportunity will meet all the CMS requirements for the NWD/SEP structural change called for in the Balancing Incentive Program. Additionally states receiving awards under this funding opportunity will have access to funding from the VHA to help Veterans access VHA-funded home and community-based services.

The Affordable Care Act, P.L. 111-148, provided $10 million per year for five years in mandatory appropriations (from FY 2010-FY 2014) for ADRCs. Because grants made under this funding opportunity will be incrementally funded for three years, this funding opportunity represents the last announcement that will be issued from these ACA mandatory ADRC appropriations. Further action by the Congress would be required to provide funding for future years after FY 2014.

***Special Opportunity to Expand HCBS Access for Veterans***

As noted above, this funding opportunity provides a *Special Opportunity to Expand HCBS Access for Veterans*. The VHA has a long-standing partnership with the U.S. Department of Health and Human Services (HHS) through partnership agreements with the Aging and Disability networks to provide VD-HCBS. The VHA expands this existing partnership under this funding opportunity and will have expenditures up to $9 million each year over the project period in successfully awarded states. Funds will be disbursed through the Veterans Integrated Service Networks (VISNs)/Veterans Administration Medical Centers (VAMCs) to purchase ADRC

Options Counseling services within the funded states. To date there are 91 ADRCs/AAAs partnering with 38 separate VA Medical Centers across 23 states. *Further details about this opportunity can be found in Attachment H.*

## 2. Functional Components of a High Performing ADRC Options Counseling Program

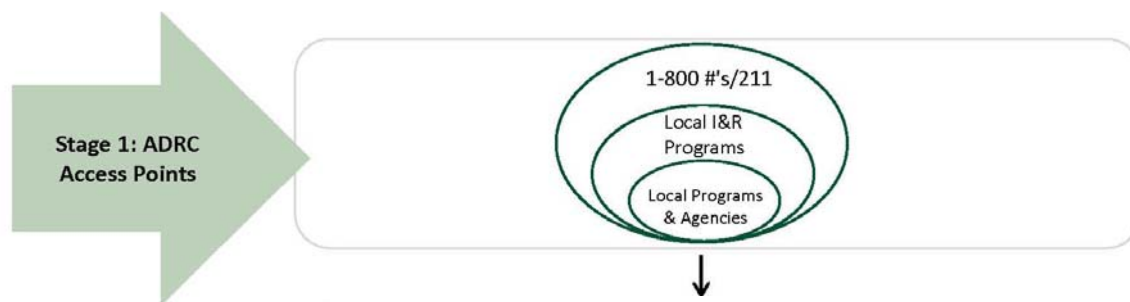
ACL, CMS and VHA's long range vision is to have ADRC Options Counseling Programs fully operational and available to individuals in every community across the country. Options Counselors provide individuals and their families with objective information on the full range of LTSS options along with one-on-one help in understanding and accessing necessary services and service delivery options (e.g., self-direction, managed care) through a person-centered planning process.

It is ACL, CMS and VHA's expectation that the five key ADRC Options Counseling functions outlined below will be implemented statewide by the end of the 3-year project period under this funding opportunity. The five key components of a fully developed ADRC Options Counseling Program include:

- **ADRC Access Points**
- **One-on-One Options Counseling**
- **Streamlined Access to Public Programs**
- **Person-Centered Transition Support**
- **Quality Assurance**

The following is a description of each component. It should be noted that these functions reflect interactions with individuals that are fluid and could occur simultaneously and do not necessarily indicate the sequences of steps that might be needed to help an individual access services.

### ADRC Access Points




A hallmark of a high performing ADRC Options Counseling Program is its ability to

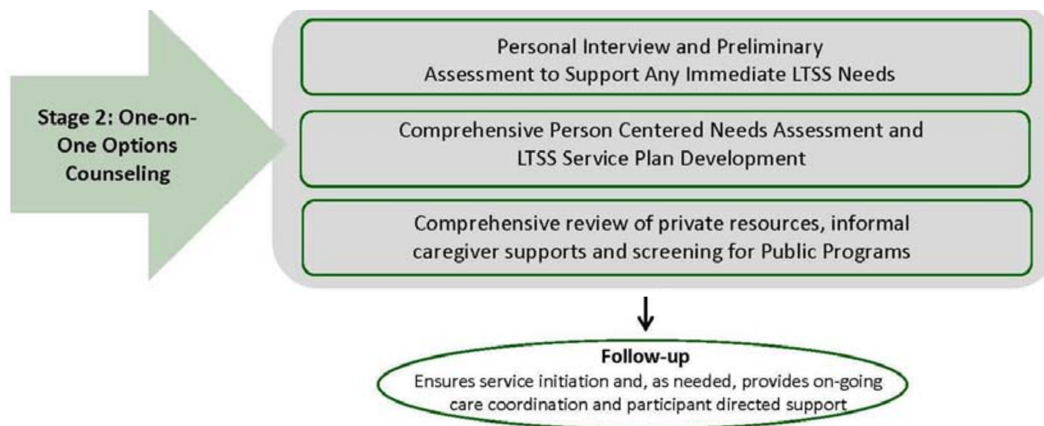
serve as a highly visible and trusted source of objective information and assistance. Any individual anywhere should be able to easily inquire about LTSS, quickly receive basic information and a referral to an ADRC Options Counseling Program. Any agency, organization, website, hotline or other entity that – as part of its normal business comes into contact with people who need help accessing LTSS – can serve as an **ADRC Access Point**. The role of an ADRC Access Point is to inform individuals about the ADRC Options Counseling Program, and then refer these individuals to a local ADRC Options Counselor. This referral may be to a trained ADRC Options Counselor within the ADRC Access Point entity, or to an outside organization. The entity responsible for the overall administration of the ADRC Options Counseling Program – either at the state or local level – is responsible for identifying and designating entities to serve as ADRC Access Points and to ensure these entities have up-to-date information and tools for identifying, informing and referring individuals to an ADRC Options Counselor. The ADRC Access Point function is a public service and should be part of the mission and regular business activity of the entity serving as ADRC Access Points. Therefore ACL grant funds should not be used pay these entities for providing information and referral functions as part of their normal business operations.

The ADRC should work with as many agencies and organizations as possibly to enlist them in serving as ADRC Access Points. Partnership efforts should be targeted to agencies and organizations involved in serving older adults and people with disabilities across the lifespan. These may include (but are not limited to):

- Area Agencies on Aging
- Local Medicaid agencies
- Centers for Independent Living
- Regional/Local intellectual and developmental disabilities services agencies
- Local Information and Referral agencies
- Senior centers
- Civic groups
- Faith-based organizations
- State Health Insurance Assistance Programs (SHIPs)
- Nursing Facilities
- Community Health Centers
- Acute care hospitals and other health facilities
- Residential Treatment Facilities
- Homeless Shelters
- Justice System (court systems, police departments, jails, prisons)
- Group homes
- Senior housing and assisted living facilities

ADRC Access Points should be able to refer individuals to the ADRC Options Counseling Program either in person, over the phone or through website links. Funded states should ensure that individuals can access the system virtually or in person and receive the same information from any location within the state. Under the Balancing Incentive Program and this funding opportunity, a statewide website and 1-800 number constitute important components to accessibility. A single 1-800 hotline (which can be an existing statewide hotline) provides universal access to individuals who prefer to speak with a live person rather than performing an online search, or for those who do not have internet access. For individuals who prefer online contact, the Balancing Incentive Program Manual (found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html) also outlines minimum standards for state LTSS website information and accessibility and plans for how the state will maintain up-to-date resources and local contact information.

**One-on-One Options Counseling**




***One-on-One Options Counseling*** should be available to all persons and family caregivers making long term support decisions regardless of an individual's income or financial assets. This includes vulnerable individuals who are low-income or at risk of hospitalization or nursing home placement, individuals which to plan for future LTSS options, and individuals able to pay for services. The job of ADRC Options Counselors is to seamlessly transition individuals and their families through a decision-making process and the LTSS system with the goal of meeting individuals at the moment when they seek out services and staying connected to them all the way to the point where they are receiving the information and/or services they need. The following components outline a fluid process where individuals can access components at various stages:

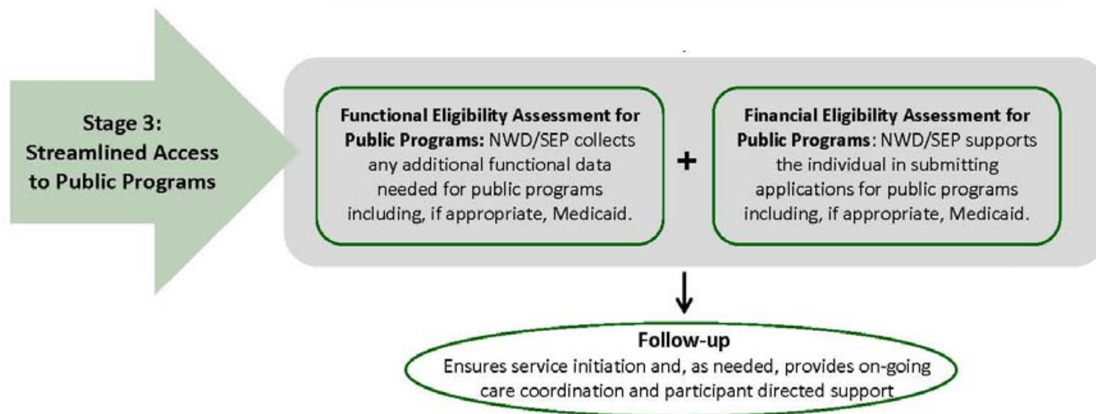
i. **A personal interview,** which includes a "one-on-one" conversation with the

individual, his or her representative, and family members as appropriate, that includes an initial screen to determine if the person needs LTSS. If so, a comprehensive person-centered planning process (see Attachment I) starts to identify an individual's strengths, values, and preferences. This process includes the identification of all current supports, and incorporates as appropriate the use of various screenings and assessment tools that may be required by various programs.

ii. **A facilitated decision-support process** that helps individuals and their families weigh the pros/cons of various options, including exploration of self-directed options where individuals are empowered to hire, fire, and pay for services and supports through an individual budgeting process, and leads to:
   A. Identification of desired and available options (including informal supports, emergency supports, funding sources, etc.); and
   B. Assisting individuals and families in determining how best to pay for and arrange the delivery of services, including helping individuals assess sufficiency of their own resources, and their eligibility for public programs, including as appropriate Medicaid, Medicare, and Veterans' benefits.

iii. **Development of a LTSS service plan and connecting people to the services and supports they need**:
   A. For those not participating in public programs, the ADRC Options Counselor helps the individual develop a person centered plan that describes:
      - the immediate next steps to be taken in the decision-making process; and
      - the mix of informal supports, community resources, and privately funded services the a person elects to use based on his or her individual preferences and needs;
   B. For those using a public option such as Medicaid, Medicare and/or Veterans programs, the process includes:
      - Facilitating eligibility and enrollment;
      - Assistance in developing a person-centered service plan;
      - Facilitating support/service activation including choice of traditional or self-directed options; and
      - Arranging for fiscal intermediary service when an individual chooses self-direction, and assisting with choice of support broker/agent.

**Streamlined Access to Public Programs**




The **Streamlined Access to Public Programs** component of the ADRC Options Counseling Program serves as a standardized process by which all individuals enroll in publicly funded LTSS, including those funded by Medicaid, the OAA and other federal and state programs and services. ADRC Options Counseling Programs have the necessary administrative functions and protocols in place to ensure individuals are enrolled and receiving the appropriate publically funded services. This may include completing a Core Standardized Assessment (if a state chose to adopt) and helping individuals complete and submit all required information and documentation for eligibility determinations. This coordination ensures that:

1. Individuals are assessed once via a common or standardized data collection tool that captures a core set of individual-level data relevant for determining the range of necessary LTSS, therefore only asking individuals to tell their story once;
2. The eligibility determination enrollment process proceeds in as streamlined and timely a manner as possible; and
3. An individual inquiring about the status of their case can visit/call their local ADRC Options Counseling Program, or go online and easily determine the status of the eligibility determination and next steps.

To expedite eligibility determinations, states may consider co-locating functional and financial eligibility determination staff at local ADRC sites. In order to effectively demonstrate cooperation and partnership for streamlining eligibility determinations, states will develop partnership agreements with the State Medicaid Agency for using the ADRC Options Counseling Program to carry out certain tasks that may be eligible for reimbursement. For more information and examples of states with these processes in place, see Attachment G.

As defined by the Balancing Incentive Program, a Core Standardized Assessment (CSA) is an important component for a streamlined eligibility determination process. This funding opportunity aligns with the Balancing Incentive Program and *strongly encourages* states to use a CSA. The CSA can be collected through the one-on-one Options Counseling process and will inform the LTSS plan.

**Person-Centered Transition Support**

ADRC Options Counseling Programs serve as a critical resource for all stakeholders by providing the healthcare system with a "front door" to the LTSS system that can quickly link their clientele to a full range of community services. The ADRC must establish formal linkages between and among the major pathways that people travel while transitioning from one service setting to another or from one public program payer to another. These pathways can include transitions from the community to hospital or nursing home, hospital discharge, preadmission screening for nursing home services, and transitions from skilled nursing facility to other settings. These pathways also represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person is permanently institutionalized or transitioned back to their own home.

The ADRC Options Counseling Program plays a pivotal role during transitions to ensure that people consider support and service options that best meet their individual needs and preferences. Local ADRC Options Counseling Programs will partner with local health systems to provide individuals and their families with transition support so they may make informed decisions and receive services quickly. These critical activities help individuals avoid being admitted unnecessarily to a nursing home or other institution. Quick connections to LTSS also break the cycle of avoidable hospital readmissions and improve individual outcomes in the community and quality of life.

In most evidence-based care transitions programs, individuals are first engaged while in acute care settings and then followed intensively over a period of approximately one to three months after discharge. Common themes across models include:

- Identification of a specific staff person to provide transitional care support;
- Interdisciplinary communication across acute, primary care and LTSS service providers/systems
- Activation of individual services; and
- Enhanced post discharge follow-up.

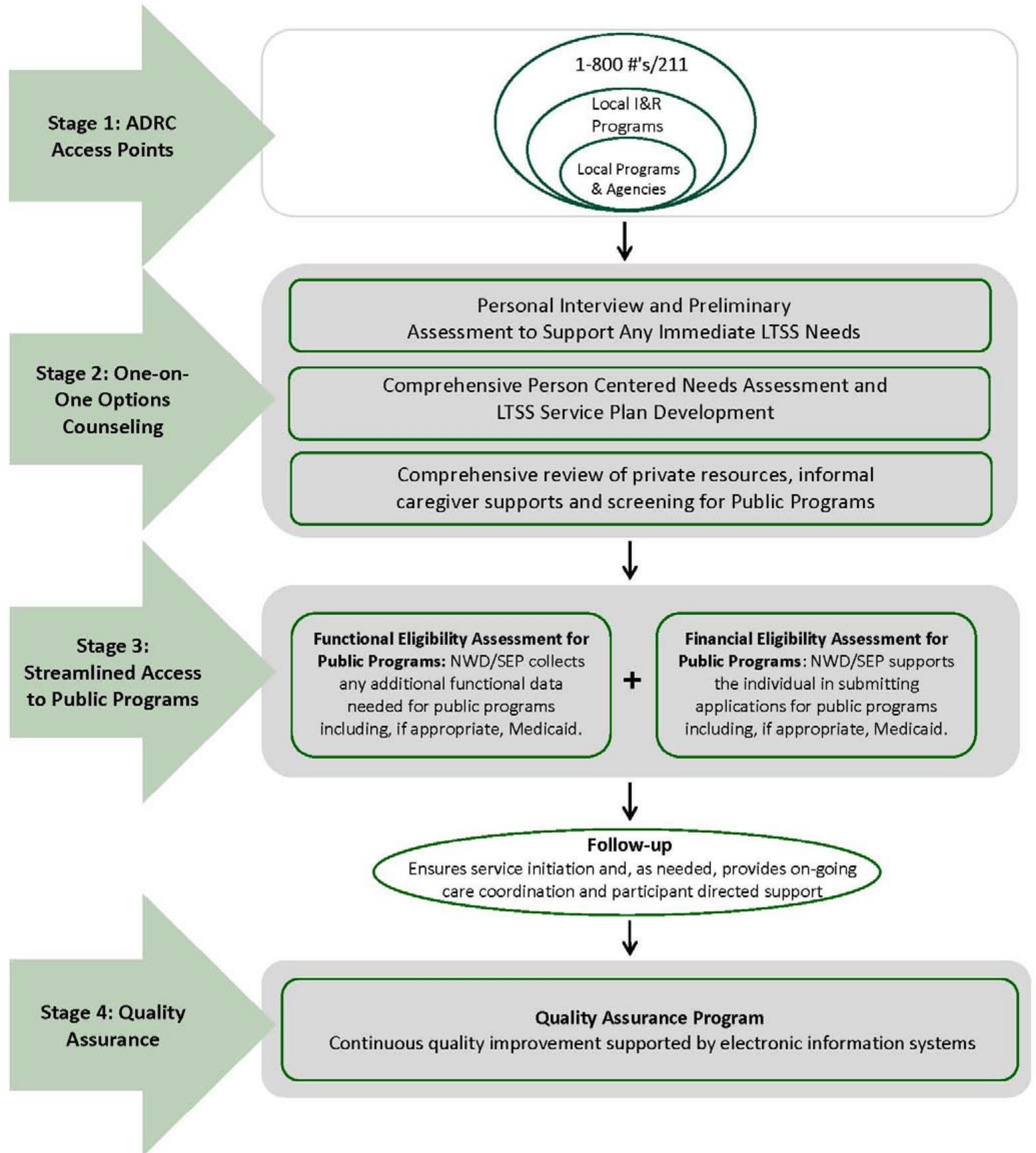
Common goals include ensuring that individuals, their families, and caregivers:

- understand post-discharge instructions for medication and self care;
- recognize symptoms that signify potential complications requiring immediate attention;
- are connected to community based LTSS; and
- schedule and attend follow-up appointments with their primary care or other physicians.

**Quality Assurance**

**Quality Assurance** is a part of every ADRC Options Counseling Program. It ensures adherence to the highest standard of customer service and that public and private investments in ADRC Options Counseling Programs are producing measurable results. All ADRC Options Counseling Programs should use electronic information systems to track individuals, services, performance, costs and outcomes. Under this funding opportunity, states and local ADRCs will continuously monitor and improve the results of services provided to individuals and their families, as well as to other organizations in the community. This will likely include linkages with other data systems, such as Medicaid, Medicare information systems and electronic health records. The Quality Assurance component of an ADRC Options Counseling Program involve formal processes for getting input and feedback from individuals and their families, system partners, managed care plans, state agencies, advocates and health care professionals on the responsiveness of operations and its on-going development. It also includes individual and family member assessment related to the outcomes of their interaction with the ADRC Options Counseling Program. Funded states will be required to use a Continuous Quality Improvement process based on a National Evaluation Framework to define, measure, track, report, and fine-tune their progress in achieving the national outcomes and performance standards the Administration for Community Living is establishing for ADRC Options Counseling Programs under this grant program.

# The ADRC Options Counseling Program Functions




**Footnote:** *The above diagram is designed to simply display the various functional components of an ADRC Options Counseling Program and does not necessarily reflect the sequences of steps that might need to be taken to help an individual to access services.*

### 3. Adopting a "No Wrong Door" Approach to Organizing and Implementing ADRC Options Counseling Programs:

A statewide infrastructure is critical to effectively reach and serve different populations with unique needs. Under this funding opportunity, ACL requires the funded states to adopt a "No Wrong Door" (NWD) approach to implementing their ADRC Options Counseling Programs.

The NWD approach operationally involves a wide array of agencies and organizations in the ADRC Options Counseling Program so it can effectively reach and serve a broad range of populations. These population groups include older adults, people with physical disabilities of all ages, people with intellectual and developmental disabilities, and individuals interested in planning and/or paying for their LTSS needs. The NWD approach gives states flexibility in determining how best to structure, organize and operate the various mandated functions of their ADRC Options Counseling Program. If necessary, states can restructure their existing ADRC programs in order to conform to the NWD approach and/or meet the performance standards and outcomes being established under this funding opportunity. States are expected to develop a collaborative process for expanding ADRC coverage, including local stakeholder engagement and partnership development strategies. States should describe their plans for supporting and funding these activities at the local level in their project narrative.

States may consider delegating some of the ADRC Options Counseling Program functional components (e.g., ADRC Access Points, One-on-One Options Counseling, and Streamlined Access to Public Programs) to a broad array of partnering agencies and organizations. Some agencies and organizations might be appropriate to carry out only the Access Point function; others only the One-on-One Counseling function. Another group of partners may be best suited to perform the Streamlined Access to Public Program functions. Some organizations may have the capacity to carry out both the One-on-One Counseling and the Streamlined Access functions, while others could implement all three functions. Numerous combinations are possible. Expanding the role of local agencies in the ADRC Options Counseling Program will require the state and its local partners to provide information, and training, and in some cases on-going technical assistance, and monitoring to the entities involved in the NWD system to ensure every individual, family members or health care professional who contacts their ADRC receives the same quality of information and help accessing the LTSS system, regardless of where they may enter. For example:

- In a NWD model, a wide variety and diverse group of organizations could

serve as ADRC Access Points *to ADRC Options Counseling*. In a NWD model, some local organizations may only have the capacity to serve as Access Points providing One-on-One Counseling.

- A small set of organizations, will implement *One-on-One ADRC Options Counseling* through the use of trained and certified Options Counselors. A sub-set of these organizations may also serve as ADRC Access Points in addition to providing *Options Counseling*.

- A smaller group of organizations will implement the *Streamlined Access to Public Programs*. This smaller group could serve just this function or also be engaged in *One-on- One Counseling* and/or serve as ADRC Access Points *to Options Counseling entities*.

By using a NWD approach, states also have flexibility using this funding opportunity to align with similar system transformation efforts and funded demonstrations. This can include coordination with structural changes required under the Balancing Incentive Program, Medicare-Medicaid alignment efforts under the CMS Financial Alignment Initiative, public housing partnerships with the MFP Demonstration, and health system and provider partnerships. These efforts should strengthen alignment between a states' health and LTSS systems as well as the state's LTSS rebalancing activities between home and community-based services and institutionally provided care. States have ultimate discretion and flexibility in designing or strengthening their NWD system.

**State Level Administration and Partnerships**

The required state level partners for this funding opportunity must include at a minimum the State Unit on Aging, State Medicaid Agency and State Disability Agencies which collectively represent aging, physical disabilities and intellectual/developmental disabilities populations. As part of this funding opportunity, the Office of the Governor must designate which state entity will serve as the lead agency in terms of management and oversight of this effort. It is essential that states establish a clear delineation of each entity's responsibilities as it relates to planning, financing, operating and overseeing the ADRC Options Counseling Program. To complement the special funding being made available under this funding opportunity from the VHA, states are encouraged to involve their State Department of Military and Veterans Affairs in their ADRC Options Counseling Program, especially as it relates to opportunities for using VHA funded LTSS to help veterans who are residing in nursing homes to transition back to the community.

States must document with clear evidence that the State Medicaid Agency will use the

state's ADRC Options Counseling Program as the state's NWD to LTSS for individuals who are eligible, or may be eligible, for Medicaid LTSS. The application must describe the sustainable funding sources that will be used for various Medicaid administrative functions to be carried out by the ADRC Options Counseling Program, including those related the ADRC's Streamlined Access to Public Programs functional responsibilities. *NOTE: Submitted applications that do not provide a letter of commitment from the State Medicaid Agency that includes a preliminary description of how the state plans to use Medicaid funds to support specific ADRC Options Counseling Program functions will fail to meet the minimum criteria established under this funding opportunity and will not be reviewed or considered for funding.*

**4. Coordination with Other ACA Initiatives**

There are opportunities for ADRC Options Counseling Programs to improve access to LTSS among new or expanded demonstrations under the Affordable Care Act (ACA). These ACA programs support states activities to test or scale models for improving health, health care and lowering costs through quality improvement. Such programs can provide sustainability options for ADRC Options Counseling Programs across all health care and LTSS payers. Applicants are encouraged to align their ADRC Options Counseling Program with the ACA initiatives described below and describe their coordination efforts within the project narrative.

**The Balancing Incentive Program** offers a targeted Federal Medical Assistance Percentage (FMAP) increase of two or five percent to states whose current expenditures on home and community-based services and support comprise less than 50% of their overall spending on long-term care. Under Balancing Incentive Program, states must make three structural changes to increase nursing home diversions and boost access to non-institutionally based services. Regardless of whether states plan to apply for Balancing Incentive Program, for this funding opportunity, states are required to adopt the NWD/SEP structural change and are strongly encouraged to adopt a CSA.

The ADRC Options Counseling Program incorporates all the features of the Balancing Incentive Program NWD, but is more comprehensive in its scope and impact. Where a NWD/SEP system under Balancing Incentive Program specifically addresses a statewide coordinated enrollment process into Medicaid funded LTSS, the ADRC Options Counseling Program takes an all payer and all-population approach to connecting individuals to LTSS. States can increase the uniformity in how individuals are evaluated for LTSS through adoption of Options Counseling national standards together with a CSA to determine eligibility for various services. Under the ADRC Options Counseling Program, trained Options Counselors will ensure that required information is gathered once, that the process is person-centered, and that

individuals are presented with the widest array of options and supports.

**Transition Support** is another ADRC Options Counseling Program function that is relevant to several ACA programs that target individuals transiting from various settings, including:

**The Partnership for Patients and Community-based Care Transitions Program (CCTP):** Created by Section 3026 of the ACA, CCTP provides funding to test models for improving transitions from the hospital to other settings and reducing readmissions for high-risk Medicare fee-for-service beneficiaries. CCTP is part of the broader Partnership for Patients—a nationwide public-private partnership to improve patient care by reducing hospital acquired conditions and preventing avoidable readmissions. Under CCTP, communities must demonstrate a community-wide approach to addressing local drivers of hospital readmissions through strong partnership between community-based organizations, local hospital systems and other post-acute care providers. Community-based organizations are paid an all-inclusive rate per eligible discharge, based on the cost of care transition services provided at the individual level. Up to $500 million in total funding is available for 2011 through 2015. CCTP may be extended or expanded if the program demonstrates financial sustainability by reducing Medicare expenditures and does not reduce quality. Since 2003, ACL and CMS have funded several initiatives related to improving the coordination of care transitions. Under the ADRC Options Counseling Program, Options Counselors can support safe and healthy transitions of individuals discharged from hospitals ensuring individuals and caregivers are receiving necessary LTSS so that a return trip to the hospital can be avoided.

**Medicare Quality Improvement Organizations Integrating Care for Populations and Communities Aim under the 10th Statement of Work**: Medicare Quality Improvement Organizations (QIOs) assist communities with developing comprehensive community-wide care transitions programs. QIOs help communities by:

- helping to convene community partners and stakeholders,
- providing community-level readmissions data and analyzing trends,
- conducting community-specific root cause analyses,
- helping communities select appropriate interventions, and
- providing other technical assistance.

Through unique data and cost analysis methods, QIOs can work with ADRCs,

their community partners and hospital systems to develop an all payer approach to supporting care transitions programs for all populations.

**Money Follows the Person Rebalancing Demonstration (MFP)**: This program helps states rebalance their long-term care systems to transition people with Medicaid from institutions to the community. Forty-three States and the District of Columbia have implemented MFP Programs. ADRCs have a long history coordinating transitions from nursing homes and other institutional long-term care to community-based settings for older adults and individuals with disabilities. Many local ADRC sites serve as the Local Contact Agency for nursing facilities under the Minimum Data Set 3.0. Older adults and individuals with disabilities who are transitioning to a community setting after living in an institution for several months or several years often need assistance with the challenging tasks such as securing affordable and accessible housing, developing a person-centered plan and arranging additional LTSS and gaining employment. Under the ADRC Options Counseling Program, individuals transitioning to a community-base setting under MFP can develop a comprehensive person-centered plan for coordinating their LTSS.

**Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents**: This is a collaborative program under Center for Medicare & Medicaid Innovation (CMMI) and the Medicare-Medicaid Coordination Office (MMCO) to support organizations partnering with nursing facilities to implement evidence-based interventions that both improve care and lower costs. The initiative is focused on long-stay nursing facility residents who are enrolled in the Medicare and Medicaid programs, with the goal of reducing avoidable inpatient hospitalizations. Through this initiative, CMS will partner with eligible, independent, non-nursing facility organizations (referred to as "enhanced care & coordination providers). The enhanced care & coordination providers will collaborate with states and nursing facilities, implementing interventions in at least 15 partnering nursing facilities. Under the ADRC Options Counseling Program, ADRCs can either act as enhanced care & coordination providers (if they submitted a letter of intent), or may partner with enhanced care & coordination providers as they develop their plans and applications to support transitions through evidence-based interventions. Additionally, trained Options Counselors can help connect individuals to a broader array of LTSS outside of an institutional setting as appropriate.

**Managed Long-Term Services and Supports:** The ACA provides incentives to states to develop new LTSS delivery and payment models, either through Medicaid waivers or through the MMCO Financial Alignment Initiative. As a result, a growing number of

states are developing and implementing managed LTSS systems for older adults and individuals with disabilities. The goals under such integrated, managed systems are to ensure that individuals and their families are aware of their service options, have access to needed services under a person-centered plan, and utilize their resources wisely. In many cases LTSS may also be bundled together with acute care to promote better service and care coordination across both dimensions, which can result in higher quality of life outcomes and accompanying cost efficiencies particularly for people with multiple chronic conditions. But even for LTSS alone, managed care can improve people's lives by realigning the fiscal incentives within a global budget to further shift the focus from institutional care to home and community-based services. To be successful, entities operating managed LTSS will need to possess or quickly incorporate solid and proven LTSS policy and operational components into their organizations.

Integrated care models and partnerships with managed care organizations offer new pathways to sustainability for ADRC Options Counseling Programs. Whether through capitated, managed fee-for-service, or global payment models, these programs plays an important role and could receive payment in an integrated care model, regardless of the payment stream. Options Counselors can follow individuals as they move through the system, from the point of entry and eligibility determination, through the development of a person-centered plan. They can also manage transitions from one level of care or one form of payment to another. ADRC Options Counselors can add value to managed systems through the development, management and oversight of home and community-based services providers, and by connecting individuals and their families to such community resources, including evidence-based health promotion/disease prevention programs. ADRCs can offer these services to managed care organizations as part of a bundled package or as unbundled, discrete services.

These ACA programs represent a limited list of examples for how the ADRC Options Counseling Program described above enhances LTSS coordination with new and existing health care payment reform, financial alignment and health system transformation activities. Under this funding opportunity, ADRC Programs are encouraged to formalize partnerships and payment strategies as part of their strategy to sustain their statewide Options Counseling Program. For a more extensive list of federal resources that may align with ADRC Options Counseling Program development, see Attachment M.

**Opportunity to Increase Elder Abuse Detection and Prevention Capability**

Elder abuse is a substantial public health and human rights problem. Available prevalence data suggest that at least 10% (or 5 million) of older Americans experience abuse each year, and many of them experience it in multiple forms.[i] In

addition, data from Adult Protective Service (APS) agencies show an increasing trend in reports of elder abuse,[ii] even though additional studies show that elder abuse is vastly under-reported[iii],[iv]. A 2011 study found that only one in 23.5 cases of abuse were reported to any agency; only one in 44 cases of financial exploitation were reported, and only one in 57 cases of neglect were reported.[v]

With this funding opportunity, states are encouraged to consider approaches, such as a pilot project within one of their local ADRCs, for using ADRC Options Counseling as a vehicle the state could use to help with the detection and prevention of elder abuse. See Attachment K for more information about elder abuse detection and prevention, including examples of evidence-based screening tools and two promising practices from existing ADRC programs.

## 5. Evaluation, Performance Standards and Reporting Requirements

### A Continuous Quality Improvement Approach

Under this funding opportunity, states are required to use a Continuous Quality Improvement (CQI) approach and a National Evaluation Framework for defining, measuring, tracking, and reporting progress in achieving the outcomes and performance standards established by ACL. In their project narratives, states will describe the CQI program they plan to use for their ADRC Options Counseling Program. The description must include the state's overall approach for organizing and managing its CQI program, general timeframes for its development and implementation, and how it will leverage and enhance existing data systems. Finally, states will describe how it plans to incorporate the proposed National Evaluation Framework into its CQI program, including the specific outcomes, performance data and stakeholder feedback to promote the continuous improvement over the 3 year project period and beyond.

All states receiving funding must agree to work with ACL, CMS and the VHA in a collaborative process during the first 6 months of the grant period to finalize the proposed National Evaluation Framework that is outlined below. This collaborative process includes reaching agreement on the methods states will use to collect and report on the data that will be required by the Framework. Funded states must also agree to use the finalized Framework and data collection methods to begin reporting to ACL before the end of the first grant year. This ensures a level of standardization in data collection and reporting across all states, and supports a national evaluation of the ADRC Options Counseling Program, including cross-state learning on approaches, strategies, and tactics for achieving key performance standards and outcomes.

## Proposed National Evaluation Framework

Attachment L outlines the proposed framework to evaluate the progress of an ADRC Options Counseling Program in achieving its performance standards and outcomes. This proposed framework will be finalized through a six month collaborative process between funded states, ACL, CMS and the VHA. Once the framework, data collection and reporting methods are finalized states can use these tools to evaluate their progress across their local ADRC sites. ACL, CMS and VHA will use the framework to evaluate the ADRC Options Counseling Program's progress across the states and nationwide. This framework will include:

- **Individual Outcomes, Indicators, and Metrics;**
- **Systems Outcomes, Indicators and Metrics; and**
- **Proposed Performance Standards, Indicators and Metrics.**

## Data Systems

As noted above, the specific outcomes and performance data required for states under this funding opportunity will be identified through a six month collaborative process between funded states, ACL, CMS and the VHS. States should consider approaches to improve information technology infrastructures across various LTSS programs and agencies needed to support CQI and National Evaluation Framework. This should include coordinating with the State Medicaid Agency on financial and functional data systems that allow ADRC Options Counselors to input and extract data necessary for developing service plans and making, or assist in making, functional and financial eligibility determinations. Another consideration includes the ability of ADRC Options Counselors to track the status of the determination process.

States should also consider approaches to incorporating the outcomes and performance data that will be required under the National Evaluation Framework into a statewide database that is capable of managing Personally Identifiable Information on individuals for whom a full service plan is developed and implemented. This may include date of birth (mm/dd/yyyy); gender (m/f); zip code + 4; last 4 digits of SSN, to better document individual-level outcomes resulting from Options Counseling and inform the development of care and payment models under the Balancing Incentive Program and other ACA initiatives.

## National Training and Certification Program

ACL, CMS and VHA envision building a national workforce of trained and qualified Options Counselors skillfully performing all the services offered by ADRC Options

Counseling Programs. ACL, CMS and VHA will work with funded states to finalize a national training curriculum. This curriculum will align with ACL's previous work in Options Counseling Standards and Core Competencies for Options Counselors. The training program will allow each participating state to access training through a variety of mechanisms, including a high performing online platform. ACL will play a significant role in covering the cost of training for all Options Counselors within the funded states. States will be able to use grant funds to cover the remaining nominal share of costs. Finalization of the training and certification process will be determined in partnerships with funded states within the first six months of the grant. This training program will be:

- *Skilled-based* and tied to specific competencies needed for effective practice;
- *Responsive* to important practice topics identified by states, agencies, Options Counseling program supervisors, Options Counselors, and educators and other stakeholders; and
- *Comprehensive* to fully prepare new Options Counselors, and to fill any gaps in knowledge or skills of workers currently in options counselor roles.

ACL, CMS and VHA will also collaborate with states on the development of a national certification process for Options Counselors. States receiving this award agree to participate in a process to finalize the skills standards related to each Options Counseling competency. These standards will serve as the basis of a portable credential for Options Counselors. ACL, CMS and VHA recognize that within the existing LTSS workforce there are competencies that have developed over the years through hands-on experience that very well could qualify some individuals for certification. As a result, states will provide feedback to ACL, CMS and VHA on the process needed to develop a National Options Counseling Training and Certification Program. Throughout the grant period, states will work with ACL, CMS and VHA on the testing and delivery of online courses and training programs for administrative and front-line staff, development of the certification program, as well as provide continuing professional education to Options Counselors.

**Technical Assistance to States**

As part of this funding opportunity, ACL will fund a National Learning Collaborative to provide technical assistance on the key outcomes and deliverables the funded states are expected to produce over the course of the grant program. The National Learning Collaborative will support peer-to-peer learning and share best practices across the states. To complement this funding opportunity, ACL, CMS and the VHA will coordinate their various technical assistance programs that to date have been funded separately to help better support states efforts to advance LTSS systems

change. This coordination provides consistent guidance to state grantees on implementation across various federal LTSS activities including the ADRC Program, Balancing Incentive Program, MFP, Local Contact Agencies and changes to Section Q of the Minimum Data Set 3.0, VD-HCBS, etc..

**Major Deliverables for Grantees Under this Funding Opportunity**

Successful applicants will:

At time of submission, provide a *letter of commitment* from the State Medicaid Agency to use the ADRC Options Counseling Program as the state's NWD system for individuals who are, or appear to be eligible for Medicaid LTSS. The letter will include a preliminary description of how the state plans to use Medicaid funds to support specific ADRC Options Counseling Program functions within the Medicaid eligibility determination process.

Within 6 Months of receipt of funds**,** have in place;

- A *final agreement* (e.g., MoU, Contract, etc) between the State Medicaid Agency and designated lead agency overseeing ADRC Options Counseling Program to utilize Medicaid funds for certain ADRC functions. This will include projected revenue from Medicaid for the ADRC over the 2.5 year project period. Agreements will be submitted to ACL and CMS; and

- A final plan for implementing the state's Continuous Quality Improvement for its ADRC Options Counseling Program, including the specific data collection and reporting and methods elected under the National Evaluation Framework. This will include the specific individual and system-wide outcomes and program performance standards, as well as the specific tools, data definitions, and data elements and information the state will submit to ACL in quarterly Data Report and Programmatic Progress Report to support federal monitoring and a nationally directed evaluation of the program.

- Agree to be delivering evidence-based care transition program in at least one area of the state.

While grantees will have identified the data elements and data sources that could be used to document program outcomes in their Work Plan, the specific tools and data definitions will be determined jointly between the grantees and the funders within 6 months of grant award

Within 12 months of receipt of funds, have in place;

- A signed Provider Agreement between a VA Medical Center and a ADRC in at least one area of the state including having identified the data elements and data sources that could be used to document program outcomes; and the projected revenue from VHA for the ADRC administrative expenses over the remaining 2 year project period,

- A final plan for ensuring that all ADRC Options Counselor in the state are trained and certified based on the training and certification program the ACL and funded states agree upon to pilot test during the 3 year-grant period.

- A description of the formal agreements that the ADRC Program has entered into with the entities within the state having lead responsibility for implementing the various ACA initiatives described in Attachment M.

- Agreed upon and be able to report on metrics of System Outcomes 1 & 2.

Within 18 months of receipt of funds**,** have in place;

- Agreed upon and be able to report on metrics of Performance Standards 1 & 2.

Within 24 months of receipt of funds**,** have in place;

- A fully developed business model approved by ACL that documents the long-term sustainability of the state's ADRC Options Counseling Program.
- Agreed upon and be able to report on metrics of Performance Standards 3 & 4.

Within 36 months of receipt of funds**,** have in place;

- Statewide coverage of a ADRC system serving all LTSS populations and all LTSS payers, including at a minimum seniors with functional impairment, individuals with physical disabilities and individuals with intellectual and developmental disabilities, their family caregivers, and private paying individuals.

- Statewide coverage of an Options Counseling Program that adheres to national

Options Counseling Standards including training and certification; and

- Statewide agreement and/or coverage for delivering Veterans services through ADRC and have identified the data elements and data sources that could be used to document program outcomes.

- Agreed upon and be able to report on Performance Standards 5 & 6.

**Statutory Authority**

The statutory authority for grants under this funding opportunity is contained in Title IV of the Older Americans Act (OAA) (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365. Title II Section 202b of the OAA (Public Law 109-365) specifically authorizes the Assistant Secretary for Aging to work with the Administrator of the Centers for Medicare & Medicaid Services to: "implement in all states Aging and Disability Resource Centers –
(A) to serve as visible and trusted sources of information on the full range of long-term care options that are available in the community, including both institutional and home and community-based care;
(B) to provide personalized and person friendly assistance to empower people to make informed decisions about their care options;
(C ) to provide coordinated and streamlined access to all publicly supported long-term care options so that individuals can obtain the care they need through a single intake, assessment and eligibility determination process;
(D) to help people to plan ahead for their future long-term care needs; and
(E) to assist, in coordination with the State Health Insurance Assistance Program, Medicare beneficiaries in understanding and accessing the Prescription Drug Coverage and prevention health benefits available under the Medicare Modernization Act."

## II. AWARD INFORMATION

| | |
|---|---|
| Total Funding Year 1: | approximately $5,600,000 in FY 2012 |
| Estimated Year 2: | approximately $6,400,000 in FY 2013 |
| Estimated Year 3: | approximately $6,400,000 in FY 2014 |
| Project Period: | 09/30/2012 – 09/29/2015 |
| Budget Periods: | 09/30/2012 – 09/29/2015 |
| Number of awards: | Funding for a total of up to 8 states/territories: |
| Type of grantee: | State Governmental Entities designated by the Governor, D.C Mayor (such as a State Unit on Aging, State Medicaid Agency, State Disability Agency, or other entity of government at the |

| | |
|---|---|
| | State level) |
| Letter of Intent Due: | June 22, 2012 |
| Type of award: | Cooperative Agreement |
| Type of activity: | Implement and sustain a statewide integrated Aging and Disability Resource Center Options Counseling Program |

**1. Amount of Funding**

The Affordable Care Act, P.L. 111-148, provided $10 million per year for five years in mandatory appropriations (from FY 2010-FY 2014) for ADRCs. Because grants made under this funding opportunity will be incrementally funded for three years, this funding opportunity represents the last announcement that will be issued from these ACA mandatory ADRC appropriations. Further action by the Congress would be required to provide funding for future years after FY 2014.

The amount of funding for each grant approved depends on the scope and quality of the proposed programs; however, ACL, CMS and VHA anticipates the funding level to support up to 8 states with $5.6 million in FY 2012 and an additional $12.8 million to support these states over the life of the program. Applicants applying for Part A should provide an estimated annual budget of:

Part A: Year 1 – Up to $700,000;
Year 2 – Up to $810,000;
Year 3 – Up to $810,000.

**2. Period of Performance**

The grant period-of-performance begins upon application approval. Funding will be awarded for the Federal Fiscal Year beginning September 30, 2012. Continued funding will be awarded on an annual basis to all participating states, contingent upon progress and subject to the availability of funds, through September 29, 2015, or until the full amount of funds have been expended. To receive continued funding in subsequent years (every 12 months), grantees will be awarded through a non-competitive process contingent upon the progress of the state towards meeting the benchmarks set forth in the state's Work Plan and detailed in the Terms and Conditions.

**3. Number of Grant Awards**

ACL, CMS and VHA will accept only one application from each state and territory interested in participating in Part A funding opportunity. It is the expectation that the designated lead agency will partner with other state agencies; however, the State

Agency designated by the Office of the Governor must be the lead applicant. The number of grant awards approved will depend on the scope (i.e., proposed enrollment and scope of services) and quality of the proposed programs. ACL, CMS and VHA anticipates the funding level to be sufficient to support a total of 8 states.

**Note: If eligible, we strongly encourage states to apply for both funding opportunities. States can only receive funding either for Part A: The Enhanced ADRC Options Counseling Program Funding Opportunity or Part B: ADRC Sustainability Program Expansion Supplemental. Please keep in mind that:**

- ***All states and territories are eligible to apply for Part A Funding Opportunity that can meet the responsive criteria; and***
- ***Only existing 2009 ADRC grantees are eligible for funding under Part B.***

Once a cooperative agreement is in place, requests to modify or amend it or the work plan may be made by ACL or the awardee at any time. Modifications and/or amendments of the Cooperative Agreement or work plan shall be effective upon the mutual agreement of both parties, except where ACL is authorized under the Terms and Conditions of award, 45 CFR Part 74 and 92, or other applicable regulation or statute to make unilateral amendments. When an award is issued the cooperative agreement terms and conditions from the funding opportunity are incorporated by reference.

## III. ELIGIBILITY INFORMATION

### 1. Eligible Applicants

Applicants must be any State Medicaid Agency, the State Unit on Aging, a State Disability Agency, or other state entity designated by the Office of the Governor. The State Medicaid Agency, State Unit on Aging, and State Disability Agency/Agencies must all be involved in the development and implementation of the state's ADRC Options Counseling Program under this Opportunity. Only one application can be submitted for a given state, and the Office of the Governor must designate the agency that will serve as the lead agency for the state's ADRC Options Counseling Program. ACL, CMS and VHA expect that the lead agency will partner with individuals and organizations representing them, local governments, and other entities in planning, developing and implementing their ADRC grant application and program.

### 2. Cost Sharing or Matching

Matching funds are not required. Please disregard any reference to "ACL Required Match" found in the Attachments. Please note, applications that include any form of

match will not receive additional consideration under the review. Match is not one of the Responsiveness or Application Screening criteria.

### 3. Responsiveness and Screening Criteria

#### Application Responsiveness Criteria

Applications that do not meet the following responsiveness criteria will be administratively eliminated and will not be reviewed:

The successful applicant will meet the following criteria:

1. Provide a *letter of commitment* from the State Medicaid Agency to use the ADRC Options Counseling Program as the state's NWD system for individuals who are or appear to be eligible for Medicaid LTSS. The letter will include a preliminary description of how the state plans use Medicaid funds to support specific ADRC Options Counseling Program functions within the Medicaid eligibility determination process.

#### Application Screening Criteria

All applications will be screened to assure a level playing field for all applicants. Applications that fail to meet the screening criteria described will **not** be reviewed and will receive **no** further consideration.

In order for an application to be reviewed, it must meet the following screening requirements:

1. Applications must be submitted electronically via http://www.grants.gov by 11:59 p.m., Eastern Time, July 25, 2012.

2. The Project Narrative section of the Application must be **double-spaced**, on 8 ½" x 11" plain white paper with **1" margins** on both sides, and a **font size of not less than 11**.

3. **The Project Narrative must not exceed 20 pages**. NOTE: The Project Work Plan, Letters of Commitment, and Vitae of Key Project Personnel **are not counted** as part of the Project Narrative for purposes of the 20-page limit. In addition, any materials submitted on behalf of the *Special Opportunity to Serve Veterans* are not counted as part of page limit.

Unsuccessful submissions will require authenticated verification from

***http://www.grants.gov*** indicating system problems existed at the time of your submission. For example, you will be required to provide an ***http://www.grants.gov*** submission error notification and/or tracking number in order to substantiate missing the application deadline.

## IV. APPLICATION AND SUBMISSION INFORMATION

### 1. Address to Request Application Package

Application materials can be obtained from http://www.grants.gov or http://www.ACL.gov/ACLRoot/Grants/Funding/index.aspx.

Please note, ACL is requiring applications for all funding opportunities to be submitted electronically through http://www.grants.gov. The Grants.gov (http://www.grants.gov) registration process can take several days. If your organization is not currently registered with http://www.grants.gov, please begin this process immediately. **For assistance with http://www.grants.gov, please contact them at** support@grants.gov **or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time.** At http://www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website (http://www.grants.gov).

Applications submitted via http://www.grants.gov:

- You may access the electronic application for this program on http://www.grants.gov. You must search the downloadable application page by the Funding Opportunity Number (HHS-2012-ACL-RO-1210**)** or CFDA number (93.517).
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. ACL strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time involved to complete the registration process.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and register in the Central Contractor Registry (CCR). You should allow a minimum of **five days** to complete the CCR registration.
- **Note**: Failure to submit the correct suffix can lead to delays in identifying your organization and access to funding in the Payment Management

System.

- Effective October 1, 2010, HHS requires all entities that plan to apply for and ultimately receive Federal grant funds from any HHS Operating/Staff Division (OPDIV/STAFFDIV) **or receive sub-awards directly from the recipients of those grant funds** to:
  1. Be registered in the CCR prior to submitting an application or plan;
  2. Maintain an active CCR registration with current information at all times during which it has an active award or an application or plan under consideration by an OPDIV; and
  3. Provide its DUNS umber in each application or plan it submits to the OPDIV.

  An award cannot be made until the applicant has complied with these requirements. At the time an award is ready to be made, if the intended recipient has not complied with these requirements, the OPDIV/STAFFDIV:
  - May be determined that the applicant is not qualified to receive an award;and
  - May use that determination as a basis for making an award to another applicant.

  Additionally, all first-tier subaward recipients must have a DUNS number at the time the subaward is made.
- Since October 1, 2003, The Office of Management and Budget has required applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements. It is entered on the SF 424. It is a unique, **nine-digit identification number**, which provides unique identifiers of single business entities. The DUNS number is *free and easy* to obtain.
- Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide: http://www.whitehouse.gov/sites/default/files/omb/grants/duns_num_guide.pdf.
- You must submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the http://www.grants.gov compatibility information and submission instructions provided at http://www.grants.gov (click on "**Vista and Microsoft Office 2007 Compatibility Information**").
- **Your application must comply with any page limitation requirements described in this funding opportunity.**
- After you electronically submit your application, you will receive an

automatic acknowledgement from http://www.grants.govthat contains http://www.grants.gov tracking number. The Administration for Community Living will retrieve your application form from http://www.grants.gov.

- After ACL retrieves your application form from http://www.grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://www.grants.gov.
- Each year organizations registered to apply for Federal grants through http://www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online and it will take about 30 minutes (http://www.ccr.gov).

Contact person regarding this Funding Opportunity:

U.S. Department of Health and Human Services
Administration for Community Living
Joseph Lugo
Center for Disability and Aging Policy
Washington, D.C. 20201
E-mail: joseph.lugo@aoa.hhs.gov

**2. Content and Form of Application Submission**

The components for each Application will include:

I. Cover Letter
II. Project Narrative
III. Letters of Support/Commitment
IV. Workplan
V. Budget Narrative

**I. Cover Letter.** A letter from the Office of the Governor identifying the agency applicant as the lead organization, indicating the title of the project, the name of the state official who will have overall responsibility for administering the program, contact person, amount of funding requested, and all major partners, departments, divisions and organizations actively collaborating in the project is required.

**II. Project Narrative**. Must be double-spaced, on 8 ½" x 11" paper with 1" margins on both sides, and a font size of not less than 11. You can use smaller font sizes to fill in the Standard Forms and Sample Formats. The suggested length for the Project Narrative is ten to twenty pages; twenty pages is the maximum length allowed. ACL will not accept applications with a Project Narrative that exceeds 20 pages. The

Letters of Commitment, Budget and Vitae of Key Personnel are not counted as part of the Project Narrative for purposes of the 20-page limit, but all of the other sections noted below are included in the limit.

The components of the Project Narrative counted as part of the 20 page limit include:

A. Summary/Abstract
B. Approach
    1. General ADRC Options Counseling Program Structure (No Wrong Door)
    2. ADRC Options Counseling Program Core Functions
    3. Core Standardized Assessment (CSA)
    4. Sustainability
C. Ongoing Evaluation and Continuous Quality Improvement
D. Coordination with Additional ACA Initiatives

**A. Summary/Abstract**. This section should include a brief - no more than 265 words maximum - description of the proposed project, including: goal(s), objectives, outcomes, and products to be developed. Detailed instructions for completing the summary/abstract are included in Attachment F of this document.

## B. Approach

### 1. General ADRC Options Counseling Program Structure (No Wrong Door Model)

**ADRC Options Counseling Program Project Management.** This section should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes. It should specify who would have day-to-day responsibility for key tasks such as: leadership of the project; monitoring the project's on-going progress, preparation of reports; communications with other partners and ACL.

**ADRC Capacity to use NWD approach to serve all populations.** This section should include current status and level of readiness of ADRC Options Counseling Program to serve all LTSS populations, including at a minimum: older adults, people with disabilities of all ages, individuals with physical, intellectual and developmental disabilities (ID/DD), and family caregivers. If not currently met, this section should include the NWD approach to be used to achieve this goal by no later than 30

months after receipt of the grant award and provide any evidence and/or outcomes that demonstrate applicants ability to achieve goal within project period.

**Achieving ADRC Options Counseling Program Statewide Coverage.** This section should include current status and level of readiness of ADRC Options Counseling Program to have statewide coverage, consistent with the specifications and requirements outlined in this funding opportunity. Applicant should provide current percentage of population and/or counties served and timeframes for reaching statewide coverage if not currently met. States should describe their collaborative process for expanding ADRC coverage, including local stakeholder engagement and partnership development strategies. Strategies must include plans for supporting ***and*** funding these activities at the local level. This section should also include the approach to be used to achieve this goal and provide any evidence and/or outcomes that demonstrate that the applicant will be able to achieve goal within project period.

## 2. ADRC Options Counseling Program Core Functions

This section should describe, in both quantitative and qualitative terms, the nature and scope of the challenges the state must address to fully implement statewide an ADRC Options Counseling Program, consistent with the specifications and requirements outlined in this funding opportunity. Applicant should describe approach to address how ADRC staffing will be determined to allow for sufficient personnel to perform ADRC Options Counseling work outlined the Vision and Executive Summary. This section should also describe state's progress in developing and implementing Options Counseling training that incorporates a comprehensive person-centered approach and that allows for self-direction.

## 3. Core Standardized Assessment (CSA)—if applicable

States are not required but are strongly encouraged to adopt a CSA. This section should describe how the applicant will develop the ADRC Options Counseling Program to deliver a CSA, consistent with the requirements of the Balancing Incentive Program. If the state does not currently utilize a CSA/CDS, this section should describe the steps and outcomes that demonstrate applicant will be able to achieve goal within project period.

### 4. Sustainability

This section should describe the applicant's approach to secure resources to continue some or all ADRC activities after Federal financial assistance through this grant has ended. This section should describe if applicant has in place an agreement with the State Medicaid Agency to support the ADRC Options Counseling Program for individuals who are eligible for, or appear to be eligible for, Medicaid LTSS. If not currently met, this section should include the approach to be used to achieve financial sustainability and provide any evidence and/or outcomes that demonstrate applicant will be able to achieve goals within project period. Applicant should describe if the state currently has an active relationship with the VAMC through a formal Provider Agreement and if the VISN and/or VAMC has provided any supportive evidence that demonstrates interest to expand program statewide and/or sustain program beyond the project period.

## C. Ongoing Evaluation and Continuous Quality Improvement

This section should describe the state's current approach to evaluating the outcomes and performance of its existing ADRC program and its level of readiness to strengthen its approach to achieve the type of CQI program called for in this funding opportunity. This section must describe the overall approach the state will use to organize and manage its enhanced CQI program, general timeframes for its development and implementation, and how it will leverage and strengthen existing data systems. The applicant will also describe its plans to incorporate the Proposed National Evaluation Framework into its CQI program, including the specific outcomes, performance data and stakeholder feedback it plans to use to promote the continuous improvement over the 3 year project period and beyond.

## D. Coordination with Other ACA Initiatives

This section should describe how ADRC Options Counseling Program is coordinating with other ACA activities. Such programs can provide sustainability options for ADRC Options Counseling Programs across all health care and LTSS payers. Applicants should describe their approach to align their ADRC Options Counseling Program with the ACA initiatives as appropriate:

- The Balancing Incentive Program;
- Community-based Care Transitions Program (CCTP);
- Money Follows the Person Rebalancing Demonstration (MFP); and

- Managed Long-Term Services and Supports.

**III. Letters of Commitment from Key Participating Organizations and Agencies**.

Applicants are strongly encouraged to include, in an appendix, letters of support indicating a history of collaboration from major partners, including individuals and advocacy groups. These letters and memorandums of agreement should critique and substantiate the applicant's readiness to implement the structural changes. *Also, as indicated in the Responsive Criteria, applicants must provide a letter of commitment from the State Medicaid Agency that includes a preliminary description of how the state plans to use Medicaid funds to support specific ADRC Options Counseling Program functions.*

Include confirmation of the commitments to the project (should it be funded) made by key collaborating organizations and agencies in this part of the application. Any organization that is specifically named to have a significant role in carrying out the project should be considered an essential collaborator. For applications submitted electronically via http://*www.grants.gov*, signed letters of commitment should be scanned and included as attachments. Applicants unable to scan the signed letters of commitment may fax them to the ACL Office of Grants Management at 202-357-3467 by the application submission deadline. In your fax, be sure to include the funding opportunity number and your agency name.

**IV. Work Plan.** Upon submission, states will submit a Work Plan that outlines in detail how the ADRC using Options Counseling will be operationalized and sustained in the state during the three year program period. The plan must be developed by the ADRC Agencies in consultation with key stakeholders.

ACL understand that several components or deliverables required in the Work Plan will continue to be defined or developed after application submission. Within six months of the date of application submission, each grantee must finalize their project deliverables with ACL, CMS and VHA.

**V. Budget Narrative/Justification**. The Budget Narrative/Justification should be provided using the format included as Attachment C of this funding opportunity. Applicants are encouraged to pay particular attention to Attachment C, which provides an example of the level of detail sought. A combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required

### 3. Submission Dates and Times

The deadline for the submission of applications under this funding opportunity is July 25, 2012. Applications must be submitted electronically by 11:59 p.m. Eastern Time, July 25, 2012.

Applications that fail to meet the application due date will not be reviewed and will receive no further consideration. You are strongly encouraged to submit your application a minimum of 3-5 days prior to the application closing date. Do not wait until the last day in the event you encounter technical difficulties, either on your end or, with ***http://www.grants.gov***. Grants.gov can take up to 48 hours to notify you of a successful submission.

Unsuccessful submissions will require authenticated verification from ***http://www.grants.gov*** indicating system problems existed at the time of your submission. For example, you will be required to provide an ***http://www.grants.gov*** submission error notification and/or tracking number in order to substantiate missing the cut off date.

Grants.gov (http://*www.grants.gov*) will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in http://*www.grants.gov*. After the Administration for Community Living retrieves your application form from http://*www.grants.gov*, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://*www.grants.gov*.

### 4. Intergovernmental Review

This funding opportunity is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs."

### 5. Funding Restrictions

The following activities are not fundable:

- Activities conducted by statewide and local Information and Referral programs;
- Construction and/or major rehabilitation of buildings;
- Basic research (e.g. scientific or medical experiments); and
- Continuation of existing projects without expansion or new and innovative

approaches.

**Note:** A recent Government Accountability Office (GAO) report number 11-43, has raised concerns about grantees and contractors charging the Federal government for additional meals outside of the standard allowance for travel subsistence known as per diem expenses. Executive Orders on Promoting Efficient Spending (EO 13589) and Delivering Efficient, Effective and Accountable Government (EO 13576) have been issued and instruct Federal agencies to promote efficient spending. Therefore, if meals are to be charged in your proposal, applicants should understand such costs must meet the following criteria outlined in the Executive Orders and HHS Grants Policy Statement:

- *Meals are generally unallowable except for the following:*
  - *For subjects and patients under study (usually a research program);*
  - *Where specifically approved as part of the project or program activity, e.g., in programs providing children's services (e.g., Headstart);*
  - *When an organization customarily provides meals to employees working beyond the normal workday, as a part of a formal compensation arrangement;*
  - *As part of a per diem or subsistence allowance provided in conjunction with allowable travel; and*
  - *Under a conference grant, when meals are a necessary and integral part of a conference, provided that meal costs are not duplicated in participants' per diem or subsistence allowances. (Note: conference grant means the sole purpose of the award is to hold a conference)*

### 6. Other Submissions Requirements

Letters of intent are required and should be emailed by June 22, 2012. In the letter of intent, applicants should indicate if:

- Applicant is applying for both Part A & B;
- Applicant is applying for just Part A; or
- Applicant is applying for just Part B.

Letters of intents should be submitted via email to:

**Joseph Lugo**
Email: joseph.lugo@aoa.hhs.gov

## V. APPLICATION REVIEW INFORMATION

### 1. Criteria

The Review Criteria listed below will be used by an Independent Review Panel to score applications. In applying for this opportunity, applicants should therefore be sure to adequately address all of the elements noted below. Applications are scored by assigning a maximum of 100 points across the following criteria:

- **A. Approach - (65 points);**
- **B. Ongoing Evaluation and Continuous Quality Improvement (10 points);**
- **C. Coordination with Additional ACA Initiatives (15 points);**
- **D. Work Plan (5 Points)**
- **E. Budget – (5 points).**

### A. Approach (65 Points)

#### 1. General ADRC Structure and Approach to A No Wrong Door System (25 Points)

Does the applicant clearly describe the roles and responsibilities of the involved state agencies? Does the applicant's approach optimize the use of potential partnerships with other organizations and/or advocacy groups, as appropriate? Does the application describe how local community-based organizations will be involved in a meaningful way in the planning and implementation of the proposed project? Do these strategies include plans for supporting ***and*** funding these activities at the local level? (15 Points)

Does the state propose a process that is culturally competent and accessible to persons with physical, intellectual and developmental disabilities? Does the application include all populations regardless of age, income or disability as part of its ADRC efforts? (5 Points)

Does the applicant provide current level of readiness of the ADRC system to adopt/strengthen a No Wrong Door approach and achieve statewide coverage? Did applicant provide current percentage of population and/or counties served and timeframes for reaching statewide coverage? Did applicant provide details for how this goal would be achieved if not currently met? (5 Points)

2. **ADRC Options Counseling Program Core Functions (15 Points)**

Does the approach outline how ADRC staffing will be determined to allow for sufficient personnel to perform ADRC Options Counseling work outlined in this funding opportunity? (5 Points)

Did the applicant provide documentation that demonstrates previous experience in delivering or receiving ADRC Options Counseling training and/or certification? Does the approach include Options Counseling training that meets the meet the criteria outlined in this funding opportunity? (5 Points)

Does the approach incorporate a comprehensive person-centered approach as described in Attachment I that allows for self-direction? In states where self-direction is not an option, did the applicant provide other mechanisms that can be used to facilitate person-centered choice and control? (5 Points)

**3. Core Standardized Assessment (CSA)—if applicable (5 Points)**

Did the applicant describe how they will develop the ADRC Options Counseling Program to deliver a Core Standardized Assessment (CSA) or adopt a Core Data Set (CDS), consistent with the requirements of the Balancing Incentive Program? (3 Points)

If the state does not currently utilize a CSA/CDS, does the applicant describe the steps and outcomes necessary to achieve this goal within project period? Does it include feasible timeframes to accomplish the tasks presented? (2 Points)

**4. Sustainability (20 Points)**

Does the State describe how the funding mechanism for the ADRC Options Counseling functions will be constructed to include the use of Medicaid funds, VA/VDHCBS, private payment, and other possible funding opportunities? Did the applicant provide a realistic approach to try to secure resources to continue some or all project activities after Federal financial assistance has ended? (10 Points)

Does the applicant have in place or document that an agreement will be executed with the State Medicaid Agency and other applicable entities

to collect, analyze and share individual-level data? (5 Points)

Does the state currently have an active relationship with the VAMC through a formal Provider Agreement?  (5 Points)

**B. Ongoing Evaluation and Continuous Quality Improvement (10 Points)**

Does the project's approach to evaluation reflect the CQI program specifications described in this funding opportunity?  Is it a thoughtful and well-designed approach that will be able to successfully measure whether or not the project has achieved its proposed outcome and performance standards?  Are the proposed data and data sources reasonable for measuring project outcomes? (5 Points)

Does this section adequately and realistically describe and document the key challenges the applicant will face and the applicant's readiness to build on its current ADRC evaluation activities and achieve the type of CQI program envisioned in this funding opportunity?  To the extent possible, was relevant baseline data included? (5 Points)

**C. Coordination with Additional ACA Initiatives (15 Points)**

Does the applicant describe how ADRC Options Counseling is coordinate funding and/or activities with other ACA activities?

- The Balancing Incentive Program (3 Points)
- Community-based Care Transitions Program (CCTP) (2 Points)
- Money Follows the Person Rebalancing Demonstration (MFP); (2 Points)
- Managed Long-Term Services and Supports (2 Points); and
- Others (2 Points each up to the maximum allowable 6 Points).

**D. Work Plan (5 Points)**

Is the project work plan clear and comprehensive?  Does it include sensible and feasible timeframes for the accomplishment of tasks presented that align with the "Major Deliverables for Grantees Under this Funding Opportunity" on page 28 of this announcement?  Do the timeframes represent a more aggressive implementation strategy to achieve major deliverables before the end of the grant? (5 Points)

**E. Budget (5 Points)**

Is the budget justified with respect to the adequacy and reasonableness of resources requested? Are budget line items clearly delineated and consistent with work plan objectives? Is it evident that local organizations will receive funding to carryout functions and responsibilities? Has a multiyear budget covering the entire proposed project period been included as well as a budget covering each individual year? (5 Points)

### 2. Review and Selection Process

ACL, CMS and VHA have the authority to approve or deny any or all proposals for funding that do not meet the programmatic requirements of this funding opportunity.

An independent review panel of at least three individuals will evaluate applications that pass the screening and meet the responsiveness criteria if applicable. These reviewers are experts in their field. Based on the Application Review Criteria the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria.

Final award decisions will be made by the Assistant Secretary for Aging (ASA). In making these decisions, the ASA will take into consideration: recommendations of the review panel; recommendations by staff; extent to which projects are coordinated with CMS efforts; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

## VI. AWARD ADMINISTRATION INFORMATION

### 1. Award Notices

Successful applicants will receive an electronic Notice of Award. The Notice of Award is the authorizing document from the U.S. Administration for Community Living authorizing official, Officer of Grants Management, and the ACL Office of Budget and Finance. Acceptance of this award is signified by the drawdown of funds from the Payment Management System. Unsuccessful applicants are generally notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail. Unless indicated otherwise in this funding opportunity, unsuccessful applications will not be retained by the agency and destroyed.

## 2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45 CFR Part 74 and 92 and the Standard Terms and Conditions, included in the Notice of Award as well as implemented through the HHS Grants Policy Statement located at *http://www.hhs.gov/grantsnet/adminis/gpd/index.htm*.

## 3. Reporting

The following reporting is in addition to the reporting activities previously described. Effective March 1, 2011, ACL requires the submission of the SF-425 (Federal Financial Report). The reporting cycle will be reflected in the Notice of Award. The ACL program progress report is due semi-annually from the start date of the award and is due within 30 days of the reporting period end date. The final progress report and SF-425 reports are due 90 days after the end of the project period.

Grantees are required to complete the federal cash transactions portion of the SF-425 within the Payment Managements System as identified in their award documents for the calendar quarters ending 3/31, 6/30, 9/30, and 12/31 through the life of their award. In addition, the fully completed SF-425 will be required as denoted in the Notice of Award terms and conditions.

## 4. FFATA and FSRS Reporting

The Federal Financial Accountability and Transparency Act (FFATA) requires data entry at the FFATA Subaward Reporting System (http://www.FSRS.gov) for all sub-awards and sub-contracts issued for $25,000 or more as well as addressing executive compensation for both grantee and sub-award organizations.

For further guidance please see the following link:
http://www.ACL.gov/ACLRoot/Grants/Reporting_Requirements/index.aspx

## 5. Additional General Provisions

Cap on Researcher Salaries - None of the funds appropriated in this program shall be used to pay the salary of an individual, through a grant, cooperative agreement or other extramural mechanism, at a rate in excess of Executive Level II (capped at $179,700).

Gun Control Prohibition - None of the funds appropriated in this program may be used, in whole or in part, to advocate or promote gun control.

Needle Exchange - Notwithstanding any other provision of the Act, no funds appropriated in this Act shall be used to carry out a program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

Publicity and Propaganda [Lobbying] – Sec. 503 (a) No part of any appropriation contained in this act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before Congress or any State or local legislature or legislative body, except in presentation of the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself. (b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government. (c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

## VII. AGENCY CONTACTS

**Project Officer:**
U.S. Department of Health and Human Services
Administration for Community Living
Washington, DC 20201
Attn: Joseph Lugo
e-mail: Joseph.Lugo@aoa.hhs.gov

**Grants Management Specialist:**
U.S. Department of Health and Human Services

Administration for Community Living
Washington, DC 20201
Attn: Rebecca Mann
e-mail: grants.office@aoa.hhs.gov

## VIII. OTHER INFORMATION

### 1. Application Submission Checklist

_____ Documentation/Support from State Medicaid Agency to use Medicaid Funding for ADRC Functions

_____ Lead State Agency Cover Letter

_____ Project Abstract

_____ Application Narrative

_____ Letters of Agreement, Endorsements and Support

_____ Work Plan

_____ Proposed Budget

***Please see Required Contents for detailed information on the application submission requirements.***

## 2. Application Elements

a. **SF 424, required –** Application for Federal Assistance (See Attachment A for Instructions).

b. **SF 424A, required – Budget Information.** (See Attachment A for Instructions; See Attachment B for an example of a completed SF 424A).

c. **Separate Budget Narrative/Justification, required** (See Attachment C for a Budget Narrative/Justification Sample Format with Examples and Attachment D for a Sample Template).
**NOTE: Applicants requesting funding for multi-year grant projects are REQUIRED to provide a Narrative/Justification for each year of potential grant funding, as well as a combined multi-year detailed Budget Narrative/Justification.**

d. **SF 424B – Assurance, required.** Note: Be sure to complete this form according to instructions and have it signed and dated by the authorized representative (see item 18d on the SF 424).

e. **Lobbying Certification, required**

f. **Proof of non-profit status, if applicable**

g. **Copy of the applicant's most recent indirect cost agreement, if requesting indirect costs.** If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

h. **Project Narrative with Work Plan, required (See Attachment E, for Sample Work Plan Format).**

i. **Organizational Capability Statement and Vitae for Key Project Personnel.**

j. **Letters of Commitment from Key Partners, if applicable.**

## 3. The Paperwork Reduction Act of 1995 (P.L. 104-13)

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The project description and Budget Narrative/Justification is approved under OMB control number 0985-0018 which expires on 8/31/13. Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

**OMB Approval No. 0985-0018**
Expiration 08/31/2013

# *Part B: ADRC Sustainability Program Expansion Supplemental Opportunity*

## Funding Opportunity and Grant Application Instructions

## Administration for Community Living

## May 31, 2012

**Department of Health and Human Services (HHS)**

**Administration for Community Living (ACL)**

**ACL Center: Center for Disability and Aging Policy**

**Funding Opportunity Title: ADRC Sustainability Program Expansion Supplemental Opportunity**

**Announcement Type: Initial**

**Funding Opportunity Number:** HHS-2012-ACL-DR-1213

**Catalog of Federal Domestic Assistance (CFDA) Number:** 93.048

**Key Dates:** The deadline date for submission of applications is 11:59 p.m., Eastern Time, on July 11, 2012. Applications that fail to meet the application due date will not be reviewed and will receive no further consideration. You are strongly encouraged to submit your application a minimum of 3-5 days prior to the application closing date. Do not wait until the last day in the event you encounter technical difficulties, either on your end or, with ***http://www.grants.gov***. Grants.gov can take up to 48 hours to notify you of a successful submission.

**Applicant's Teleconference**

An open information teleconference for applicants of the funding opportunities under this announcement will be held as follows:

- June 12, 2012 at 1PM EST. The toll-free teleconference phone number will be 1-800-369-3160, pass code: 1683139

Total Funding Year 1: approximately $6,900,000 in FY 2012

| | |
|---|---|
| Project Period: | 09/30/2012 – 09/29/2013 |
| Budget Periods: | 09/30/2012 – 09/29/2013 |
| Number of awards: | Funding for a total of up to 40 states/territories: |
| Type of grantee: | Existing FY 2009 ADRC Grantees |
| Letter of Intent Due: | June 22, 2012 |
| Type of award: | Cooperative Agreement |
| Type of activity: | Sustain a statewide integrated ADRC Options Counseling Program by accessing ongoing Medicaid, Medicare and/or VA funding streams |

## I. FUNDING OPPORTUNITY DESCRIPTION – PART B

The Administration for Community Living—ACL and CMS have provided grants to states since 2003 to develop person-centered systems of access, known as "Aging and Disability Resource Centers", "No Wrong Door (NWD)" or "Single Entry Point" system, to make it easier for individuals to access long-term services and support (LTSS) options. Programs are designed to serve as visible and trusted sources where people access objective information on their LTSS options including Medicare benefits, as well as one-on-one counseling to ensure that consumers, including private pay individuals, fully understand available options to meet their needs and preferences. For people who qualify for public programs, the one-stop provides a streamlined eligibility process leading to all LTSS programs. For purposes of this funding opportunity, we are using the label "The Enhanced Aging and Disability Resource Center Options Counseling Program."

This funding opportunity is specifically designed to help support states in pursuing and developing sustainability strategies for ADRC Options Counseling Program in conjunction with their health systems transformation and funding from the Center for Medicare and Medicaid (CMS) and Veteran Health Administration (VHA). Under this opportunity, States will continue to work toward developing a high performing statewide ADRC Options Counseling Program as outlined in their own statewide ADRC development/expansion plans and as described in the 2012 ACL, CMS, VHA Funding Opportunity "***The Enhanced Aging and Disability Resource Center Options Counseling Program."***

Successful applicants will seek to achieve the following two key sustainability goals as part of this funding opportunity:

1. Strengthening the capacity of the ADRC Options Counseling Program to serve people of all ages, income levels and disabilities by adopting a "No Wrong Door" approach that operationally involves a wide array of community agencies and organizations in the ADRC so it can effectively serve a broad range of populations; and

2. Developing financially sustainable ADRC models that includes revenue from multiple public programs (including Medicaid, Medicare, the Older Americans Act, the Veterans Health Administration and other programs) to cover expenses associated with such tasks as:
    - outreach,
    - screening/assessing individuals' need for LTSS,

- working with individuals and their families to develop service plans,
- linking individuals to needed services, helping individuals to use self-directed service models,
- assisting individuals in determining their eligibility for public programs, and
- Follow-up.

Based on the experience to-date with ADRCs across the nation, and the importance of having an ADRC infrastructure that can effectively reach and serve different populations with unique LTSS needs as well as different ethnic and cultural groups, ACL is encouraging funded states to adopt a "No Wrong Door" (NWD) approach to implementing their ADRC Options Counseling Programs. The NWD approach operationally involves a wide array of agencies and organizations in the ADRC Program so it can effectively reach and serve a broad range of populations, including older adults, individuals with physical disabilities of all ages, individuals with intellectual and developmental disabilities, as well as individuals who can pay for their own services. This NWD approach gives states considerable flexibility in determining how best to structure, organize and operate the various mandated functions of their ADRC Program. For more information about the NWD approach, see Adopting a "No Wrong Door" Approach to Organizing and Implementing ADRC Options Counseling Programs as part of the 2012 ACL, CMS, VHA Funding Opportunity "***The Enhanced Aging and Disability Resource Center Options Counseling Program."***

**Major Performance Markers for Grantees Under this Funding Opportunity**

Successful applicants will:

**Within 12 Months of receipt of funds have one of the following in place;**

1) a formal agreement with the Single State Medicaid Agency with the end goal of making some of the tasks performed by the ADRC Options Counseling Program eligible for Federal Medicaid reimbursement. For example, MoU, Contract, etc between Medicaid agency and designated lead agency overseeing ADRC Options Counseling Program to utilize Medicaid funds for ADRC functions and projected annual revenue from Medicaid. Grantees should also have identified the data elements and data sources that will be used to document program outcomes; or

2) a signed Provider Agreement between a VA Medical Center and a ADRC in at least one area of the state which has identified the data elements and data sources that could be used to document Veteran Directed HCBS program outcomes; and the projected annual revenue from VHA for the ADRC

administrative expenses; or

3) a formal agreement between the ADRC Options Counseling Program with a coordinated care delivery model and identification of ongoing Medicare or other Federal funding for ADRC operations. For example, documentation of a formal agreement(s) that the ADRC Program has entered into with the entities within the state having lead responsibility for implementing the various ACA initiatives and identified Medicare funding streams to support ADRC functions. See the description of the different types of coordinated care initiatives in the 2012 ACL, CMS, VHA Funding Opportunity "***The Enhanced Aging and Disability Resource Center Options Counseling Program".***

**Reporting Requirements**

Grantees will submit to ACL two semi-annual Progress Report describing their activities, outcomes related to their goals, challenges and lessons learned with final copies of formal funding agreements developed during the grant period attached.

## II. AWARD INFORMATION

Total Funding Year 1: approximately $6,900,000 in FY 2012
Project Period: 09/30/2012 – 09/29/2013
Budget Periods: 09/30/2012 – 09/29/2013
Number of awards: Funding for a total of up to 40 states/territories:
Type of grantee: Existing FY 2009 ADRC Grantees
Letter of Intent Due: June 22, 2012
Type of award: Cooperative Agreement
Type of activity: Sustain a statewide integrated ADRC Options Counseling Program by accessing Medicaid, Medicare and/or VA funding streams

### 1. Amount of Funding

ACL, CMS and VHA will accept only one application from each state and territory interested in participating in Part B funding opportunity. The number of grant awards approved will depend on the scope (i.e., proposed enrollment and scope of services) and quality of the proposed programs. ACL, CMS and VHA anticipate the funding level to be sufficient to support a total of 40 states. Applicants applying for Part B should provide an estimated annual budget of:

- **Up to 90% of FY 2011 Award (see attachment N to see the maximum amount of funding each state is eligible to receive for Part B).**

The Affordable Care Act, P.L. 111-148, provided $10 million per year for five years in mandatory appropriations (from FY 2010-FY 2014) for ADRCs. Because grants made under this funding opportunity will be incrementally funded for three years, this funding opportunity represents the last announcement that will be issued from these ACA mandatory ADRC appropriations. Further action by the Congress would be required to provide funding for future years after FY 2014.

### 2. Period of Performance

The grant period-of-performance begins upon application approval. Funding will be awarded for the Federal Fiscal Year beginning September 30, 2012 and ending September 29, 2013.

### 3. Number of Grant Awards

**Note: If eligible, we strongly encourage states to apply for both funding opportunities. States can only receive funding either for Part A: The Enhanced ADRC Options Counseling Program Funding Opportunity or Part B: ADRC Sustainability Program Expansion Supplemental. Please keep in mind that:**

- ***All states and territories are eligible to apply for Part A Funding Opportunity that can meet the responsive criteria; and***
- ***Only existing 2009 ADRC grantees are eligible for funding under Part B.***

Once a cooperative agreement is in place, requests to modify or amend it or the work plan may be made by ACL or the awardee at any time. Modifications and/or amendments of the Cooperative Agreement or work plan shall be effective upon the mutual agreement of both parties, except where ACL is authorized under the Terms and Conditions of award, 45 CFR Part 74 and 92, or other applicable regulation or statute to make unilateral amendments. When an award is issued the cooperative agreement terms and conditions from the funding opportunity are incorporated by reference.

## III. ELIGIBILITY INFORMATION

### 1. Eligible Applicants

Applicants must be an existing ADRC grantee who received a three year award in FY 2009. Only one application can be submitted for a given state.

### 2. Cost Sharing or Matching

Matching funds are not required. Please disregard any reference to "ACL Required

Match" found in the Attachments. Please note, applications that include any form of match will not receive additional consideration under the review. Match is not one of the Responsiveness or Application Screening criteria.

### 3. Screening Criteria

**Application Screening Criteria**

All applications will be screened to assure a level playing field for all applicants. Applications that fail to meet the screening criteria described will **not** be reviewed and will receive **no** further consideration.

In order for an application to be reviewed, it must meet the following screening requirements:

4. Applications must be submitted electronically via http://www.grants.gov by 11:59 p.m., Eastern Time, July 11, 2012.

5. The Project Narrative section of the Application must be **double-spaced**, on 8 ½" x 11" plain white paper with **1" margins** on both sides, and a **font size of not less than 11**.

6. **The Project Narrative must not exceed 3 pages**.

Unsuccessful submissions will require authenticated verification from ***http://www.grants.gov*** indicating system problems existed at the time of your submission. For example, you will be required to provide an ***http://www.grants.gov*** submission error notification and/or tracking number in order to substantiate missing the application deadline.

## IV. APPLICATION AND SUBMISSION INFORMATION

### 1. Address to Request Application Package

Application materials can be obtained from http://www.grants.gov or http://www.ACL.gov/ACLRoot/Grants/Funding/index.aspx.

Please note, ACL is requiring applications for all funding opportunities to be submitted electronically through http://www.grants.gov. The Grants.gov (http://www.grants.gov) registration process can take several days. If your

organization is not currently registered with http://www.grants.gov, please begin this process immediately. **For assistance with http://www.grants.gov, please contact them at** support@grants.gov **or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time.** At http://www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website (http://www.grants.gov).

Applications submitted via http://www.grants.gov:

- You may access the electronic application for this program on http://www.grants.gov. You must search the downloadable application page by the Funding Opportunity Number (HHS-2012-ACL-DR-1213)
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. ACL strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time involved to complete the registration process.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and register in the Central Contractor Registry (CCR). You should allow a minimum of **five days** to complete the CCR registration.
- **Note**: Failure to submit the correct suffix can lead to delays in identifying your organization and access to funding in the Payment Management System.
- Effective October 1, 2010, HHS requires all entities that plan to apply for and ultimately receive Federal grant funds from any HHS Operating/Staff Division (OPDIV/STAFFDIV) **or receive sub-awards directly from the recipients of those grant funds** to:
  4. Be registered in the CCR prior to submitting an application or plan;
  5. Maintain an active CCR registration with current information at all times during which it has an active award or an application or plan under consideration by an OPDIV; and
  6. Provide its DUNS umber in each application or plan it submits to the OPDIV.

  An award cannot be made until the applicant has complied with these requirements. At the time an award is ready to be made, if the intended recipient has not complied with these requirements, the OPDIV/STAFFDIV:

  - May be determined that the applicant is not qualified to receive an

award;and

- May use that determination as a basis for making an award to another applicant.

Additionally, all first-tier subaward recipients must have a DUNS number at the time the subaward is made.

- Since October 1, 2003, The Office of Management and Budget has required applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements. It is entered on the SF 424. It is a unique, **nine-digit identification number**, which provides unique identifiers of single business entities. The DUNS number is *free and easy* to obtain.
- Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide: http://www.whitehouse.gov/sites/default/files/omb/grants/duns_num_guide.pdf.
- You must submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the http://www.grants.gov compatibility information and submission instructions provided at http://www.grants.gov (click on "**Vista and Microsoft Office 2007 Compatibility Information**").
- **Your application must comply with any page limitation requirements described in this funding opportunity.**
- After you electronically submit your application, you will receive an automatic acknowledgement from http://www.grants.govthat contains http://www.grants.gov tracking number. The Administration for Community Living will retrieve your application form from http://www.grants.gov.
- After the Administration for Community Living retrieves your application form from http://www.grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://www.grants.gov.
- Each year organizations registered to apply for Federal grants through http://www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online and it will take about 30 minutes (http://www.ccr.gov).

Contact person regarding this Funding Opportunity:

U.S. Department of Health and Human Services

Administration for Community Living
Joseph Lugo
Center for Disability and Aging Policy
Washington, D.C. 20201
Phone Number: (202) 357-3417
E-mail: joseph.lugo@aoa.hhs.gov

## 2. Content and Form of Application Submission

The components for each Application will include:

I. Project Narrative
II. Budget Narrative

**I. Project Narrative**. Must be double-spaced, on 8 ½" x 11" paper with 1" margins on both sides, and a font size of not less than 11. You can use smaller font sizes to fill in the Standard Forms and Sample Formats. The suggested length for the Project Narrative is one to three pages; with three pages being the maximum length allowed. ACL will not accept applications with a Project Narrative that exceeds 3 pages. The Budget is not counted as part of the Project Narrative for purposes of the 3-page limit, but all of the other sections noted below are included in the limit.

The components of the Project Narrative counted as part of the 3 page limit include:
1) Approach to implementing ADRC Options Counseling Program using NWD model.
2) Description with corresponding timelines of the specific sustainability strategy to be pursued during the 12-month grant period (e.g., agreement with State Medicaid Agency for ADRCs to serve as NWD/SEP as described in Balancing Incentive Payment program)

**II. Budget Narrative/Justification**. The Budget Narrative/Justification should be provided using the format included as Attachment C of this funding opportunity. Applicants are required to submit their current level of spending, pending obligations, and current balance for their 2009 ADRC grant. Applicants are encouraged to pay particular attention to Attachment C, which provides an example of the level of detail sought.

## 3. Submission Dates and Times

The deadline for the submission of applications under this funding opportunity is July 11, 2012. Applications must be submitted electronically by 11:59 p.m. Eastern Time, July 11, 2012.

Applications that fail to meet the application due date will not be reviewed and will receive no further consideration. You are strongly encouraged to submit your application a minimum of 3-5 days prior to the application closing date. Do not wait until the last day in the event you encounter technical difficulties, either on your end or, with ***http://www.grants.gov***. Grants.gov can take up to 48 hours to notify you of a successful submission.

Unsuccessful submissions will require authenticated verification from ***http://www.grants.gov*** indicating system problems existed at the time of your submission. For example, you will be required to provide an ***http://www.grants.gov*** submission error notification and/or tracking number in order to substantiate missing the cut off date.

Grants.gov (http://*www.grants.gov*) will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in http://*www.grants.gov*. After the Administration for Community Living retrieves your application form from http://*www.grants.gov*, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://*www.grants.gov*.

**4. Intergovernmental Review**

This funding opportunity is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs."

**5. Funding Restrictions**

The following activities are not fundable:

- Activities conducted by statewide and local Information and Referral programs
- Construction and/or major rehabilitation of buildings
- Basic research (e.g. scientific or medical experiments); and
- Continuation of existing projects without expansion or new and innovative approaches.

**Note:** A recent Government Accountability Office (GAO) report number 11-43, has raised concerns about grantees and contractors charging the Federal government for additional meals outside of the standard allowance for travel subsistence known as per diem expenses. Executive Orders on Promoting Efficient Spending (EO 13589) and Delivering Efficient, Effective and Accountable Government (EO 13576) have

been issued and instruct Federal agencies to promote efficient spending. Therefore, if meals are to be charged in your proposal, applicants should understand such costs must meet the following criteria outlined in the Executive Orders and HHS Grants Policy Statement:

- *Meals are generally unallowable except for the following:*
    - *For subjects and patients under study (usually a research program);*
    - *Where specifically approved as part of the project or program activity, e.g., in programs providing children's services (e.g., Headstart);*
    - *When an organization customarily provides meals to employees working beyond the normal workday, as a part of a formal compensation arrangement;*
    - *As part of a per diem or subsistence allowance provided in conjunction with allowable travel; and*
    - *Under a conference grant, when meals are a necessary and integral part of a conference, provided that meal costs are not duplicated in participants' per diem or subsistence allowances. (Note: conference grant means the sole purpose of the award is to hold a conference)*

### 6. Other Submissions Requirements

Letters of intent <u>are required</u> and should be emailed by June 22, 2012. In the letter of intent, applicants should indicate if:

- Applicant is applying for both Part A & B;
- Applicant is applying for just Part A; or
- Applicant is applying for just Part B.

Letters of intents should be submitted via email to:

**Joseph Lugo**
Email: joseph.lugo@aoa.hhs.gov

## V. APPLICATION REVIEW INFORMATION

### 1. Criteria

The Review Criteria listed below will be used by an Independent Review Panel to score applications. In applying for this opportunity, applicants should therefore be

sure to adequately address all of the elements noted below. Applications are scored by assigning a maximum of 100 points across the following criteria:

| | |
|---|---|
| **Approach to No Wrong Door Model** | **(30 Points)** |
| **Sustainability Strategy** | **(60 points)** |
| **Budget** | **(10 points)** |

Approach to No Wrong Door Model Weight: 30 Points

Does applicant describe the extent to which their ADRCs already use the NWD approach? Do they identify gaps in populations currently covered and how new partners (e.g., Centers for Independent Living, Regional ID/DD Agencies, Community Mental Health Centers) will become more involved in the operation of ADRCs? Do they include letters of support or other documents to support new partnerships? (30 Points)

Sustainability Strategy Weight: 60 points

Do they describe what type of funding will be sought during the 12 month grant period and how the funding agreement(s), funding application(s) or funding mechanism(s) will be constructed to draw down Medicaid funds, Medicare funds, VA/VDHCBS, or other federal funding for ADRC Options Counseling Program functions? Does applicant identify why they have chosen to pursue these particular sustainability strategies? (20 points)

Does the State clearly identify the steps they need to take in order for their ADRC Options Counseling Program to fulfill the requirements of their targeted funder (e.g., structural changes necessary for Balancing Incentive Program, data sharing agreements executed)? (20 points)

Are the project timelines clear, sensible and feasible for the accomplishment of tasks presented? Do the timeframes represent an aggressive implementation strategy to achieve sustainable statewide coverage before the end of the grant and after the conclusion of the grant? (20 Points)

Budget Weight: 10 points

Is the budget justified with respect to the adequacy and reasonableness of resources requested? Are budget line items clearly delineated and consistent with objectives? (5 points)

Does the applicant provide the current expenditures and balance of their 2009 ADRC

Grant received from ACL? (5 points)

### 2. Review and Selection Process

ACL has the authority to approve or deny any or all proposals for funding that do not meet the programmatic requirements of this funding opportunity.

An independent review panel of at least three individuals will evaluate applications that pass the screening and meet the responsiveness criteria if applicable. These reviewers are experts in their field. Based on the Application Review Criteria the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria.

Final award decisions will be made by the Assistant Secretary for Aging (ASA). In making these decisions, the ASA will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

## VI. AWARD ADMINISTRATION INFORMATION

### 1. Award Notices

Successful applicants will receive an electronic Notice of Award. The Notice of Award is the authorizing document from the U.S. Administration for Community Living authorizing official, Officer of Grants Management, and the ACL Office of Budget and Finance. Acceptance of this award is signified by the drawdown of funds from the Payment Management System. Unsuccessful applicants are generally notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail. Unless indicated otherwise in this funding opportunity, unsuccessful applications will not be retained by the agency and destroyed.

### 2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45 CFR Part 74 and 92 and the Standard Terms and Conditions, included in the Notice of Award as well as implemented through the HHS Grants Policy Statement located at *http://www.hhs.gov/grantsnet/adminis/gpd/index.htm*.

### 3. Reporting

Effective March 1, 2011, ACL requires the submission of the SF-425 (Federal Financial Report). The reporting cycle will be reflected in the Notice of Award. The ACL program progress report is due semi-annually from the start date of the award and is due within 30 days of the reporting period end date. The final progress report and SF-425 reports are due 90 days after the end of the project period.

Grantees are required to complete the federal cash transactions portion of the SF-425 within the Payment Managements System as identified in their award documents for the calendar quarters ending 3/31, 6/30, 9/30, and 12/31 through the life of their award. In addition, the fully completed SF-425 will be required as denoted in the Notice of Award terms and conditions.

**4. FFATA and FSRS Reporting**

The Federal Financial Accountability and Transparency Act (FFATA) requires data entry at the FFATA Subaward Reporting System (http://www.FSRS.gov) for all sub-awards and sub-contracts issued for $25,000 or more as well as addressing executive compensation for both grantee and sub-award organizations.

For further guidance please see the following link:
http://www.ACL.gov/ACLRoot/Grants/Reporting_Requirements/index.aspx

**5. Additional General Provisions**

Cap on Researcher Salaries - None of the funds appropriated in this program shall be used to pay the salary of an individual, through a grant, cooperative agreement or other extramural mechanism, at a rate in excess of Executive Level II (capped at $179,700).

Gun Control Prohibition - None of the funds appropriated in this program may be used, in whole or in part, to advocate or promote gun control.

Needle Exchange - Notwithstanding any other provision of the Act, no funds appropriated in this Act shall be used to carry out a program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

Publicity and Propaganda [Lobbying] – Sec. 503 (a) No part of any appropriation contained in this act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet,

publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before Congress or any State or local legislature or legislative body, except in presentation of the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself. (b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government. (c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

## VII. AGENCY CONTACTS

**Project Officer:**
U.S. Department of Health and Human Services
Administration for Community Living
Washington, DC 20201
Attn: Joseph Lugo
e-mail: Joseph.Lugo@aoa.hhs.gov

**Grants Management Specialist:**
U.S. Department of Health and Human Services
Administration for Community Living
Washington, DC 20201
Attn: Rebecca Mann
e-mail: grants.office@AoA.hhs.gov

## VIII. OTHER INFORMATION

### 1. Application Submission Checklist

_____ Application Narrative

_____ Proposed Budget

***Please see Required Contents for detailed information on the application submission requirements.***

**2. Application Elements**

SF 424, required – Application for Federal Assistance

SF 424A, required – Budget Information.

Separate Budget Narrative/Justification, required

NOTE: Applicants requesting funding for multi-year grant projects are REQUIRED to provide a Narrative/Justification for each year of potential grant funding, as well as a combined multi-year detailed Budget Narrative/Justification.

SF 424B – Assurance, required. Note: Be sure to complete this form according to instructions and have it signed and dated by the authorized representative (see item 18d on the SF 424).

Lobbying Certification, required

Proof of non-profit status, if applicable

Copy of the applicant's most recent indirect cost agreement, if requesting indirect costs. If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

Project Narrative with Work Plan, required

Organizational Capability Statement and Vitae for Key Project Personnel.

Letters of Commitment from Key Partners, if applicable.

**3. The Paperwork Reduction Act of 1995 (P.L. 104-13)**

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The project description and Budget Narrative/Justification is approved under OMB control number 0985-0018 which expires on 8/31/13. Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

# ATTACHMENTS

**Attachment A:**
**Instructions for Completing Required Forms**
**(SF 424, Budget (SF 424A), Budget Narrative/Justification)**

**Attachment B:**
**SF 424 – Sample Format with Example**

**Attachment C:**
**Budget Narrative/Justification Format – Sample Format with Examples**

**Attachment D:**
**Budget Narrative/Justification – Sample Template**

**Attachment E:**
**Project Work Plan - Sample Template**

**Attachment F:**
**Instructions for Completing the Summary/Abstract**

**Attachment G:**
**Medicaid Support for ADRC Functions**

**Attachment H:**
**Veterans Health Administration Opportunity for ADRCs**

**Attachment I:**
**Person-Centered Assessment and Planning**

**Attachment J:**
**Draft National Options Counseling Standards**

**Attachment K:**
**Elder Abuse Detection and Prevention**
**Increasing ADRC Options Counseling Programs**
**Role and Capacity**

**Attachment L:**
**Proposed National Evaluation Framework**

**Attachment M:**
**Other Federal Opportunities that May Align with ADRCs**

**Attachment N:**
**Grant Funding Amounts for**
**Part B**

# Attachment A: Instructions for Completing Required Forms

**(SF 424, Budget (SF 424A), Budget Narrative/Justification)**

This section provides step-by-step instructions for completing the four (4) standard Federal forms required as part of your grant application, including special instructions for completing Standard Budget Forms 424 and 424A. Standard Forms 424 and 424A are used for a wide variety of Federal grant programs, and Federal agencies have the discretion to require some or all of the information on these forms. ACL does not require all the information on these Standard Forms. Accordingly, please use the instructions below in lieu of the standard instructions attached to SF 424 and 424A to complete these forms.

**a. Standard Form 424**

1. **Type of Submission:** (REQUIRED): Select one type of submission in accordance with agency instructions.

- Preapplication
- Application
- Changed/Corrected Application – If ACL requests, check if this submission is to change or correct a previously submitted application.

2. **Type of Application**: (REQUIRED) Select one type of application in accordance with agency instructions.

- New
- Continuation
- Revision

3. **Date Received:** Leave this field blank.

4. **Applicant Identifier**: Leave this field blank

5a **Federal Entity Identifier**: Leave this field blank

5b. **Federal Award Identifier**: For new applications leave blank. For a continuation or revision to an existing award, enter the previously assigned Federal award (grant) number.

6. **Date Received by State:** Leave this field blank.

7. **State Application Identifier:** Leave this field blank.

8. **Applicant Information**: Enter the following in accordance with agency instructions:

**a. Legal Name**: (REQUIRED): Enter the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the Grants.gov website (http://www.grants.gov).

**b. Employer/Taxpayer Number (EIN/TIN):** (REQUIRED): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service. In addition, we encourage the organization to include the correct suffix used to identify your organization in order to properly align access to the Payment Management System.

**c. Organizational DUNS**: (REQUIRED) Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov website (http://www.grants.gov). Your DUNS number can be verified at http://www2.zapdata.com/CompanyLookup.do.

**d. Address**: (REQUIRED) Enter the complete address including the county.

**e. Organizational Unit:** Enter the name of the primary organizational unit (and department or division, if applicable**)** that will undertake the project.

**f. Name and contact information of person to be contacted on matters involving this application**: Enter the name (First and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and email address (Required) of the person to contact on
matters related to this application.

9. **Type of Applicant:** (REQUIRED) Select the applicant organization "type" from the following drop down list.
A. State Government B. County Government C. City or Township Government D. Special District Government E. Regional Organization F. U.S. Territory or Possession G. Independent School District H. Public/State Controlled Institution of Higher Education I. Indian/Native American Tribal Government (Federally Recognized) J. Indian/Native American Tribal Government (Other than Federally Recognized) K.

Indian/Native American Tribally Designated Organization L. Public/Indian Housing Authority M. Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education) N. Nonprofit without 501C3 IRS Status (Other than Institution of Higher Education) O. Private Institution of Higher Education P. Individual Q. For-Profit Organization (Other than Small Business) R. Small Business S. Hispanic-serving Institution T. Historically Black Colleges and Universities (HBCUs) U. Tribally Controlled Colleges and Universities (TCCUs) V. Alaska Native and Native Hawaiian Serving Institutions W. Non-domestic (non-US) Entity X. Other (specify)

10. **Name Of Federal Agency**: (REQUIRED) Enter U.S. Administration for Community Living

11. **Catalog Of Federal Domestic Assistance Number/Title:** The CFDA number can be found on page one of this funding opportunity.

12. **Funding Opportunity Number/Title:** (REQUIRED) The Funding Opportunity Number and title of the opportunity can be found on page one of this funding opportunity.

13. **Competition Identification Number/Title:** Leave this field blank.

14. **Areas Affected By Project:** List the largest political entity affected (cities, counties, state etc).

15. **Descriptive Title of Applicant's Project:** (REQUIRED) Enter a brief descriptive title of the project (This is not a narrative description).

16. **Congressional Districts Of**: (REQUIRED) 16a. Enter the applicant's Congressional District, and 16b. Enter all district(s) affected by the program or project. Enter in the format: 2 characters State Abbreviation – 3 characters District Number, e.g., CA-005 for California 5th district, CA-012 for California 12$^{th}$ district, NC-103 for North Carolina's 103rd district. If all congressional districts in a state are affected, enter "all" for the district number, e.g., MD-all for all congressional districts in Maryland. If nationwide, i.e. all districts within all states are affected, enter US-all. See the below website to find your congressional district:

http://www.house.gov/Welcome.shtml

17. **Proposed Project Start and End Dates**: (REQUIRED) Enter the proposed start date and final end date of the project**. If you are applying for a multi-year grant, such as a 3 year grant project, the final project end date will be 3 years after the proposed start date.** In general, all start dates on the SF424 should be the 1$^{st}$ of the

month and the end date of the last day of the month of the final year, for example 7/01/2012 to 6/30/2015. The Grants Officer can alter the start and end date at their discretion.

18. **Estimated Funding:** (REQUIRED) If requesting multi-year funding, enter the full amount requested from the Federal Government in line item 18.a., as a multi-year total. For example and illustrative purposes only, if year one is $100,000, year two is $100,000, and year three is $100,000, then the full amount of Federal funds requested would be reflected as $300,000. The amount of matching funds is denoted by lines b. through f. with a combined Federal and non-Federal total entered on line g. Lines b. through f. represents contributions to the project by the applicant and by your partners during the total project period, broken down by each type of contributor. The value of in-kind contributions should be included on appropriate lines, as applicable.

**NOTE:** Applicants should review cost sharing or matching principles contained in Subpart C of 45 CFR Part 74 or 45 CFR Part 92 before completing Item 18 and the Budget Information Sections A, B and C noted below.

All budget information entered under item 18 should cover the total project period. For sub-item 18a, enter the Federal funds being requested. Sub-items 18b-18e is considered matching funds. The dollar amounts entered in sub-items 18b-18f must total at least 1/3rd of the amount of Federal funds being requested (the amount in 18a). For a full explanation of ACL's match requirements, see the information in the box below. For sub-item 18f (program income), enter only the amount, if any, that is going to be used as part of the required match. Program Income submitted as match will become a part of the award match and recipients will be held accountable to meet their share of project expenses even if program income is not generated during the award period.

There are two types of match: 1) non-Federal cash and 2) non-Federal in-kind. In general, costs borne by the applicant and cash contributions of any and all third parties involved in the project, including sub-grantees, contractors and consultants, are considered **matching funds**. Examples of **non-Federal cash match** includes budgetary funds provided from the applicant agency's budget for costs associated with the project. Generally, most contributions from sub-contractors or sub-grantees (third parties) will be non-Federal in-kind matching funds. Volunteered time and use of third party facilities to hold meetings or conduct project activities may be considered in-kind (third party) donations.

> NOTE: **Indirect charges** may only be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and

Human Services or another Federal agency; or (2) the applicant is a state or local government agency. State governments should enter the amount of indirect costs determined in accordance with DHHS requirements. **If indirect costs are to be included in the application, a copy of the approved indirect cost agreement must be included with the application. Further, if any sub-contractors or sub-grantees are requesting indirect costs, a copy of the latest approved indirect cost agreements must also be included with the application, or reference to an approved cost allocation plan.**

**ACL's Match Requirement**

Under this and other OAA programs, ACL will fund no more than 75 % of the **project's total cost**, which means the applicant must cover at least 25% of the **project's total cost** with non-Federal resources. In other words, for every three (3) dollars received in Federal funding, the applicant must contribute at least one (1) dollar in non-Federal resources toward the project's total cost (i.e., the amount on line 18g.). This "three-to-one" ratio is reflected in the following formula which you can use to calculate your **minimum** required match:

$$\frac{\text{Federal Funds Requested * Match Percentage}}{\text{Inverse Match Percentage}} = \text{Minimum Match Requirement}$$

**Examples of varying match levels:**

$$1)\ \frac{\$100{,}000 \text{ (federal funds requested) * } 5\% \text{ (match)}}{95\%} = \$5{,}263$$

$$2)\ \frac{\$100{,}000 \text{ * } 25\% \text{(match)}}{75\%} = \$33{,}333$$

$$3)\ \frac{\$100{,}000 \text{ * } 35\% \text{(match)}}{65\%} = \$53{,}846$$

$$4)\ \frac{\$100{,}000 \text{ * } 45\% \text{(match)}}{55\%} = \$81{,}818$$

**If the required non-Federal share is not provided by the completion date of the funded project period, ACL will reduce the Federal dollars awarded when closing out the award to meet the match percentage, which may result in a requirement to return Federal funds.**

19. **Is Application Subject to Review by State Under Executive Order 12372 Process?** Check c. Program is not covered by E.O. 12372

20. **Is the Applicant Delinquent on any Federal Debt?** (Required) This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

21. **Authorized Representative**: (Required) To be signed and dated by the authorized representative of the applicant organization. Enter the name (First and last name required) title (Required), telephone number (Required), fax number, and email address (Required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

**b. Standard Form 424A**

| NOTE: Standard Form 424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this ACL program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. Unless otherwise indicated, the SF 424A should reflect a multi year budget. See Attachment B. |
|---|

## Section A - Budget Summary

**Line 5**: Leave columns (c) and (d) blank. Enter TOTAL Federal costs in column (e) and total non-Federal costs (including third party in-kind contributions and any program income to be used as part of the grantee match) in column (f). Enter the sum of columns (e) and (f) in column (g).

## Section B - Budget Categories

Column 1: Enter the breakdown of how you plan to use the Federal funds being
requested by object class category (see instructions for each object class category in Attachment C).

Column 2: Enter the breakdown of how you plan to use the non-Federal share by object class category.

Column 5: Enter the total funds required for the project (sum of Columns 1 and 2) by object class category.

## Section C – Non Federal Resources

Column A: Enter the federal grant program.

Column B: Enter in any non-federal resources that the applicant will contribute to the project.

Column C: Enter in any non-federal resources that the state will contribute to the project.

Column D: Enter in any non-federal resources that other sources will contribute to the project.

Column E: Enter the total non-federal resources for each program listed in column A.

## Section D –Forecasted Cash Needs

**Line 13:** Enter Federal forecasted cash needs broken down by quarter for the first year only.

**Line 14**: Enter Non-Federal forecasted cash needs broken down by quarter for the first year.

Line 15: Enter total forecasted cash needs broken down by quarter for the first year.

Note: This area is not meant to be one whereby an applicant merely divides the requested funding by four and inserts that amount in each quarter but an area where thought is given as to how your estimated expenses will be incurred during each quarter. For example, if you have initial start up costs in the first quarter of your award reflect that in quarter one or you do not expect to have contracts awarded and funded until quarter three, reflect those costs in that quarter.

## Section E – Budget Estimates of Federal Funds Needed for Balance of the Project (i.e. subsequent years 2, 3, 4 or 5 as applicable).

Column A: Enter the federal grant program

Column B (first): Enter the requested year two funding.

Column C (second): Enter the requested year three funding.

Column D (third): Enter the requested year four funding, if applicable.

Column E (forth): Enter the requested year five funding, if applicable.

## Section F – Other Budget Information

**Line 21:** Enter the total Indirect Charges

**Line 22**: Enter the total Direct charges (calculation of indirect rate and direct charges).

**Line 23:** Enter any pertinent remarks related to the budget.

**Separate Budget Narrative/Justification Requirement**

**Applicants requesting funding for multi-year grant programs are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding. A separate Budget Narrative/Justification is also REQUIRED for each potential year of grant funding requested.**

For your use in developing and presenting your Budget Narrative/Justification, a sample format with examples and a blank sample template have been included in these Attachments. In your Budget Narrative/Justification, you should include a breakdown of the budgetary costs for all of the object class categories noted in Section B, across three columns: Federal; non-Federal cash; and non-Federal in-kind. Cost breakdowns, or justifications, are required for any cost of $1,000 or for the thresholds as established in the examples. The Budget Narratives/Justifications should fully explain and justify the costs in each of the major budget items for each of the object class categories, as described below. Non-Federal cash as well as, sub-contractor or sub-grantee (third party) in-kind contributions designated as match must be clearly identified and explained in the Budget Narrative/Justification The full Budget Narrative/Justification should be included in the application immediately following the SF 424 forms.

Line 6a: **Personnel**: Enter total costs of salaries and wages of applicant/grantee staff. Do

not include the costs of consultants, which should be included under 6h - Other.

**In the Justification**: Identify the project director, if known. Specify the key staff, their titles, and time commitments in the budget justification.

Line 6b: **Fringe Benefits**: Enter the total costs of fringe benefits unless treated as part of

an approved indirect cost rate.

**In the Justification**: If the total fringe benefit rate exceeds 35% of Personnel costs, provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement, etc. A percentage of 35% or less does not require a break down but you must show the percentage charged for each full/part time employee.

Line 6c: **Travel**: Enter total costs of all travel (local and non-local) for staff on the project. NEW: Local travel is considered under this cost item not under Other. Local transportation (all travel which does not require per diem is considered local travel). Do not enter costs for consultant's travel - this should be included in line 6h.

**In the Justification**: Include the total number of trips, number of travelers, destinations, purpose (e.g., attend conference), length of stay, subsistence allowances (per diem), and transportation costs (including mileage rates).

Line 6d: **Equipment**: Enter the total costs of all equipment to be acquired by the project. For all grantees, "equipment" is non-expendable tangible personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. If the item does not meet the $5,000 threshold, include it in your budget under Supplies, line 6e.

**In the Justification**: Equipment to be purchased with federal funds must be justified as necessary for the conduct of the project. The equipment must be used for project-related functions. Further, the purchase of specific items of equipment should not be included in the submitted budget if those items of equipment, or a reasonable facsimile, are otherwise available to the applicant or its sub-grantees.

Line 6e: **Supplies**: Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d.

**In the Justification**: . For any grant award that has supply costs in excess of 5% of total direct costs (Federal or Non-Federal), you must provide a detailed break down of the supply items (e.g., 6% of $100,000 = $6,000 – breakdown of supplies needed). If the 5% is applied against $1 million total direct costs (5% x $1,000,000 = $50,000) a detailed breakdown of supplies is not needed. Please note: any supply costs of $5,000 or less regardless of total direct costs does not require a detailed budget breakdown (e.g., 5% x $100,000 = $5,000 – no breakdown needed).

Line 6f: **Contractual**: Regardless of the dollar value of any contract, you must follow your established policies and procedures for procurements and meet the minimum standards established in the Code of Federal Regulations (CFR’s) mentioned below. Enter the total costs of all contracts, including (1) procurement contracts (except those which belong on other lines such as equipment, supplies, etc.). Note: The 33% provision has been removed and line item budget detail is not required as long as you meet the established procurement standards. Also include any awards to organizations for the provision of technical assistance. Do not include payments to individuals on this line. Please be advised: A subrecipient is involved in financial assistance

activities by receiving a sub-award and a subcontractor is involved in procurement activities by receiving a sub-contract. Through the recipient, a subrecipient performs work to accomplish the public purpose authorized by law. Generally speaking, a sub-contractor does not seek to accomplish a public benefit and does not perform substantive work on the project. It is merely a vendor providing goods or services to directly benefit the recipient, for example procuring landscaping or janitorial services. In either case, you are encouraged to clearly describe the type of work that will be accomplished and type of relationship with the lower tiered entity whether it be labeled as a subaward or subcontract.

**In the Justification**: Provide the following three items – 1) Attach a list of contractors indicating the name of the organization; 2) the purpose of the contract; and 3) the estimated dollar amount. If the name of the contractor and estimated costs are not available or have not been negotiated, indicate when this information will be available. The Federal government reserves the right to request the final executed contracts at any time. If an individual contractual item is over the small purchase threshold, currently set at $100K in the CFR, you must certify that your procurement standards are in accordance with the policies and procedures as stated in 45 CFR 74.44 for non-profits and 92.36 for states, in lieu of providing separate detailed budgets. This certification should be referenced in the justification and attached to the budget narrative.

Line 6g: **Construction**: Leave blank since construction is not an allowable costs for this program.

Line 6h: **Other**: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (i.e. for project volunteers this is different from personnel fringe benefits),non-contractual fees and travel paid directly to *individual* consultants, postage, space and equipment rentals/lease, printing and publication, computer use, training and staff development costs (i.e. registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then rest assured this is where it belongs.

Note: A recent Government Accountability Office (GAO) report number 11-43, has raised considerable concerns about grantees and contractors charging the Federal government for additional meals outside of the standard allowance for travel subsistence known as per diem expenses. If meals are to be charged towards the grant they must meet the following criteria outlined in the Grants Policy Statement:

- *Meals are generally unallowable except for the following:*

- *For subjects and patients under study(usually a research program);*
- *Where specifically approved as part of the project or program activity, e.g., in programs providing children's services (e.g., Headstart);*
- *When an organization customarily provides meals to employees working beyond the normal workday, as a part of a formal compensation arrangement;*
- *As part of a per diem or subsistence allowance provided in conjunction with allowable travel; and*
- *Under a conference grant, when meals are a necessary and integral part of a conference, provided that meal costs are not duplicated in participants' per diem or subsistence allowances (Note: the sole purpose of the grant award is to hold a conference).*

**In the Justification**: Provide a reasonable explanation for items in this category. For example, individual consultants explain the nature of services provided and the relation to activities in the work plan or indicate where it is described in the work plan. Describe the types of activities for staff development costs.

Line 6i: **Total Direct Charges**: Show the totals of Lines 6a through 6h.

Line 6j: **Indirect Charges**: Enter the total amount of indirect charges (costs), if any. If no indirect costs are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another federal agency; or (2) the applicant is a state or local government agency. **State governments should enter the amount of indirect costs determined in accordance with DHHS requirements.** An applicant that will charge indirect costs to the grant must enclose a copy of the current rate agreement. Indirect Costs can only be claimed on Federal funds, more specifically, they are to only be claimed on the Federal share of your direct costs. Any unused portion of the grantee's eligible Indirect Cost amount that are not claimed on the Federal share of direct charges can be claimed as un-reimbursed indirect charges, and that portion can be used towards meeting the recipient match.

Line 6k: **Total**: Enter the total amounts of Lines 6i and 6j.

Line 7: **Program Income**: As appropriate, include the estimated amount of income, if any, you expect to be generated from this project that you wish to designate as match (equal to the amount shown for Item 15(f) on Form 424). **Note:** Any program income indicated at the bottom of Section B and for item

15(f) on the face sheet of Form 424 will be included as part of non-Federal match and will be subject to the rules for documenting completion of this pledge. If program income is expected, but is not needed to achieve matching funds, **do not** include that portion here or on Item 15(f) of the Form 424 face sheet. Any anticipated program income that will not be applied as grantee match should be described in the Level of Effort section of the Program Narrative.

**c. Standard Form 424B – Assurances (required)**

This form contains assurances required of applicants under the discretionary funds programs administered by the Administration for Community Living. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

**d. Certification Regarding Lobbying (required)**

This form contains certifications that are required of the applicant organization regarding lobbying. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

**Proof of Non-Profit Status (as applicable)**

Non-profit applicants must submit proof of non-profit status. Any of the following constitutes acceptable proof of such status:

- A copy of a currently valid IRS tax exemption certificate.
- A statement from a state taxing body, state attorney general, or other appropriate state official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of the organization's certificate of incorporation or similar document that clearly establishes non-profit status.

**Indirect Cost Agreement**

Applicants that have included indirect costs in their budgets must include a copy of the current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency. This is optional for applicants that have not included indirect costs in their budgets.

# Attachment B: Standard Form 424A – Sample Format

OMB Approval No. 0348-0044

## BUDGET INFORMATION--Non-Construction Programs

**SECTION A-BUDGET SUMMARY**

| Grant Program Function or Activity (a) | Catalog of Federal Domestic Assistance Number (b) | Estimated Unobligated Funds | | New or Revised Budget | | |
|---|---|---|---|---|---|---|
| | | **Federal** (c) | **Non-Federal** (d) | **Federal** (e) | **Non-Federal** (f) | **Total** (g) |
| 1. LifeSpan Respite | 93.048 | | | 340,294 | 113,433 | 453,727 |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. **TOTALS** | | | | 340,294 | 113,433 | 453,727 |

**SECTION B-BUDGET CATEGORIES**

| 6. **Object Class Categories** | GRANT PROGRAM, FUNCTION OR ACTIVITY | | | | **Total** (5) |
|---|---|---|---|---|---|
| | (1) Year 1 | (2) Year 2 | (3) Year 3 | (4) | |
| a. **Personnel** | 71,254 | 30,000 | 35,000 | | 136,254 |
| b. **Fringe Benefits** | 26,114 | 15,000 | 20,000 | | 61,114 |
| c. **Travel** | 7,647 | 5,000 | 5,000 | | 17,647 |
| d. **Equipment** | 10,000 | 0 | 0 | | 10,000 |
| e. **Supplies** | 9,460 | 2,500 | 1,000 | | 12,960 |
| f. **Contractual** | 30,171 | 0 | 0 | | 30,171 |
| g. **Construction** | 0 | 0 | 0 | | |
| h. **Other** | 11,480 | 55,833 | 47,334 | | 114,647 |
| i. **Total Direct Charges** (sum 6a-h) | 166,126 | 108,333 | 108,334 | | 382,793 |
| j. **Indirect Charges @** | 20,934 | 25,000 | 25,000 | | 70,934 |
| k. **TOTALS** (sum 6i and j) | 187,060 | 133,333 | 133,334 | | 453,727 |

OMB Approval No. 0348-0044

# BUDGET INFORMATION--Non-Construction Programs

| | | | | | |
|---|---|---|---|---|---|
| 7. **Program Income** | None | | | | |

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| **SECTION C-NON-FEDERAL RESOURCES** | | | | |
|---|---|---|---|---|
| (a) Grant Program | (b) Applicant | (c) State | (d) Other sources | (e) TOTALS |
| 8. Life Span Respite | 80,886 | | 32,547 | 113,433 |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. **TOTALS** (sum of lines 8 and 11) | 80,886 | | 32,547 | 113,433 |

| **SECTION D-FORECASTED CASH NEEDS** | | | | | |
|---|---|---|---|---|---|
| 13. **Federal** | Total for 1st Year | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter |
| | 140,294 | 20,000 | 50,000 | 20,000 | 50,294 |
| 14. **Non-Federal** | 46,766 | 12,000 | 10,000 | 9,000 | 15,766 |
| 15. **TOTAL** (sum of lines 13 and 14) | | | | | |

| **SECTION E-BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT** | | | | |
|---|---|---|---|---|
| **(a) Grant Program** | Future Funding Periods (Years) | | | |
| | (b) First | (c) Second | (d) | (e) |
| 16. Life Span Respite | 100,000 | 100,000 | | |
| 17. | | | | |

| 18. | | | | |
|---|---|---|---|---|
| 19. | | | | |
| 20. **TOTALS** (sum of lines 16-19) | | | | |

| **SECTION F-OTHER BUDGET INFORMATION**<br>(Attach additional Sheets if Necessary) | |
|---|---|
| 21. **Direct Charges:** | 22. **Indirect Charges:** |
| 23. **Remarks** | |

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## Attachment C: Budget Narrative/Justification – Sample Format

**NOTE : Applicants requesting funding for a multi-year grant program are REQUIRED to provide a detailed Budget Narrative/Justification for EACH potential year of grant funding requested.**

| Object Class Category | Federal Funds | Non-Federal Cash | Non-Federal In-Kind | TOTAL | Justification |
|---|---|---|---|---|---|
| **Personnel** | $47,700 | $23,554 | $0 | $71,254 | **Federal**<br>Project Director (name) = .5 FTE @ $95,401/yr = $47,700<br>**Non-Fed Cash**<br>Officer Manager (name) = .5FTE @ $47,108/yr = $23,554<br><br>Total $71,254 |
| **Fringe Benefits** | $17,482 | $8,632 | $0 | $26,114 | **Federal**<br>Fringe on Project Director at 36.65% = $17,482<br>FICA (7.65%)<br>Health (25%)<br>Dental (2%)<br>Life (1%)<br>Unemployment (1%)<br>**Non-Fed Cash**<br>Fringe on Office Manager at 36.65% = $8,632<br>FICA (7.65%)<br>Health (25%)<br>Dental (2%)<br>Life (1%)<br>Unemployment (1%) |

| Object Class Category | Federal Funds | Non-Federal Cash | Non-Federal In-Kind | TOTAL | Justification |
|---|---|---|---|---|---|
| Travel | $4,707 | $2,940 | $0 | $7,647 | **Federal**<br>Local travel: 6 TA site visits for 1 person<br>Mileage: 6RT @ .585 x 700 miles $2,457<br>Lodging: 15 days @ $110/day $1,650<br>Per Diem: 15 days @ $40/day $600<br>Total $4,707<br>**Non-Fed Cash**<br>Travel to National Conference in (Destination) for 3 people<br>Airfare 1 RT x 3 staff @ $500 $1,500<br>Lodging: 3 days x 3 staff @ $120/day $1,080<br>Per Diem: 3 days x 3 staff @ $40/day $360<br>Total $2,940 |
| Equipment | $10,000 | $0 | $0 | $10,000 | *No Equipment requested OR:*<br>Call Center Equipment<br>Installation = $5,000<br>Phones = $5,000<br>Total $10,000 |
| Supplies | $3,700 | $5,760 | $0 | $9,460 | **Federal**<br>2 desks @ $1,500 $3,000<br>2 chairs @ $300 $600<br>2 cabinets @ $200 $400<br>**Non-Fed Cash**<br>2 Laptop computers $3,000<br>Printer cartridges @ $50/month $300<br>Consumable supplies (pens, paper, clips etc…)<br>@ $180/month $2,160<br>Total $9,460 |

| Object Class Category | Federal Funds | Non-Federal Cash | Non-Federal In-Kind | TOTAL | Justification |
|---|---|---|---|---|---|
| **Contractual** | $30,171 | $0 | $0 | $30,171 | (organization name, purpose of contract and estimated dollar amount)<br>Contract with AAA to provide respite services:<br>11 care givers @ $1,682 = $18,502<br>Volunteer Coordinator = $11,669<br>Total $30,171<br><br>*If contract details are unknown due to contract yet to be made provide same information listed above and:*<br>A detailed evaluation plan and budget will be submitted by (date), when contract is made. |
| **Other** | $5,600 | $0 | $5,880 | $11,480 | **Federal**<br>2 consultants @ $100/hr for 24.5 hours each = $4,900<br>Printing 10,000 Brochures @ $.05 = $500<br>Local conference registration fee (name conference) = $200<br>Total $5,600<br>**In-Kind**<br>**Volunteers**<br>15 volunteers @ $8/hr for 49 hours = $5,880 |
| **Indirect Charges** | $20,934 | $0 | $0 | $20,934 | 21.5 % of salaries and fringe = $20,934<br><br>IDC rate is attached. |
| **TOTAL** | $140,294 | $40,886 | $5,880 | $187,060 | |

## Attachment D: Budget Narrative/Justification –– Sample Template

**NOTE : Applicants requesting funding for a multi-year grant program are REQUIRED to provide a detailed Budget Narrative/Justification for EACH potential year of grant funding requested.**

| Object Class Category | Federal Funds | Non-Federal Cash | Non-Federal In-Kind | TOTAL | Justification |
|---|---|---|---|---|---|
| Personnel | | | | | |
| Fringe Benefits | | | | | |
| Travel | | | | | |
| Equipment | | | | | |
| Supplies | | | | | |
| Contractual | | | | | |
| Other | | | | | |
| Indirect Charges | | | | | |
| TOTAL | | | | | |

## Attachment E: Project Work Plan – Sample Template

**NOTE : Applicants requesting funding for a multi-year grant program are REQUIRED to provide a Project Work Plan for EACH potential year of grant funding requested.**

**Goal:**

**Measurable Outcome(s):**

* **Time Frame** (Start/End Dates by Month in Project Cycle)

| Major Objectives | Key Tasks | Lead Person | 1* | 2* | 3* | 4* | 5* | 6* | 7* | 8* | 9* | 10* | 11* | 12* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |

| Major Objectives | Key Tasks | Lead Person | 1* | 2* | 3* | 4* | 5* | 6* | 7* | 8* | 9* | 10* | 11* | 12* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |

## Attachment E: Project Work Plan, Page 2 – Sample Template

**Goal:**

**Measurable Outcome(s):**

* **Time Frame** (Start/End Dates by Month in Project Cycle)

| Major Objectives | Key Tasks | Lead Person | 1* | 2* | 3* | 4* | 5* | 6* | 7* | 8* | 9* | 10* | 11* | 12* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3. | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |

| Major Objectives | Key Tasks | Lead Person | 1* | 2* | 3* | 4* | 5* | 6* | 7* | 8* | 9* | 10* | 11* | 12* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |

# Attachment E: Project Work Plan, Page 3 – Sample Template

**Goal:**

**Measurable Outcome(s):**

* **Time Frame** (Start/End Dates by Month in Project Cycle)

| Major Objectives | Key Tasks | Lead Person | 1* | 2* | 3* | 4* | 5* | 6* | 7* | 8* | 9* | 10* | 11* | 12* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5. | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 6. | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | |

**NOTE: Please do note infer from this sample format that your work plan must have 6 major objectives. If you need more pages, simply repeat this format on additional pages.**

# Attachment F: Instructions for Completing the Project Summary/Abstract

- All applications for grant funding must include a Summary/Abstract that concisely describes the proposed project. It should be written for the general public.
- To ensure uniformity, limit the length to 265 words or less, on a single page with a font size of not less than 11, doubled-spaced.
- The abstract must include the project's goal(s), objectives, overall approach (including target population and significant partnerships), anticipated outcomes, products, and duration. The following are very simple descriptions of these terms, and a sample Compendium abstract.

  **Goal(s)** – broad, overall purpose, usually in a mission statement, i.e. what you want to do, where you want to be.

  **Objective(s) –** narrow, more specific, identifiable or measurable steps toward a goal. Part of the planning process or sequence (the "how") to attain the goal(s).

  **Outcomes -** measurable results of a project. Positive benefits or negative changes, or measurable characteristics that occur as a result of an organization's or program's activities. (Outcomes are the end-point)

  **Products –** materials, deliverables.

- A model abstract/summary is provided below:

The Delaware Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), in **partnership** with the Delaware Lifespan Respite Care Network (DLRCN) and key stakeholders will, in the course of this two-year project, expand and maintain a statewide coordinated lifespan respite system that builds on the infrastructure currently in place. The **goal** of this project is to improve the delivery and quality of respite services available to families across age and disability spectrums by expanding and coordinating existing respite systems in Delaware. The **objectives** are: 1) to improve lifespan respite infrastructure; 2) to improve the provision of information and awareness about respite service; 3) to streamline access to respite services through the Delaware ADRC; 4) to increase availability of respite services. Anticipated **outcomes** include: 1) families and caregivers of all

ages and disabilities will have greater options for choosing a respite provider; 2) providers will demonstrate increased ability to provide specialized respite care; 3) families will have streamlined access to information and satisfaction with respite services; 4) respite care will be provided using a variety of existing funding sources and 5) a sustainability plan will be developed to support the project in the future. The expected **products** are marketing and outreach materials, caregiver training, respite worker training, a Respite Online searchable database, two new Caregiver Resource Centers (CRC), an annual Respite Summit, a respite voucher program and 24/7 telephone information and referral services.

## 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-87). In many situations, this is accomplished by allocating costs by the percentage

[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).

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**

| LTSS Front Door Functions | | Medicaid FFP | Medicaid FMAP (for Waiver Services) |
|---|---|---|---|
| Screening/ Personal Interview[2] | Screening/Intake for Medicaid or Other Public LTC Programs | Yes | |
| | Pre-screening for Nursing Home Admission such as medical assessment or case management. | No | 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 | |
| | 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 |
| | Conducting Level of Care Assessments (NF) | Only government agencies | |
| | Making Financial Eligibility Determinations (ADRC or co-located with ADRC) | Only government agencies | |
| | Making Functional Eligibility Determinations for HCBS (ADRC or co-located with ADRC) | Only government agencies | |
| | 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 |
| | Facilitate program enrollment for publicly funded services | Yes | |
| | Initiate Services through participant direction | *Potentially* | Yes |
| | Facilitate and assure service providers have been contacted and establish first date of service | Yes | Yes |
| | Care Coordination | Potentially | Yes |

| | LTSS Front Door Functions | Medicaid FFP | Medicaid FMAP (for Waiver 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 |
| | Confirm that individual is receiving publicly funded services as planned | Yes | Yes |
| | 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, se**veral 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<br>2. Assisting in application process | Staff 100% dedicated to Medicaid compensable activities. |
| Montana (2008) | 1. Outreach<br>2. Information and Referral<br>3. Intake<br>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<br>2. Information, Referral and Intake<br>3. Short-term Stabilization<br>4. Case Review Assistance<br>5. Long Term Care (LTC) Needs and Supporting Resources Assessment<br>6. LTC Options Counseling<br>7. Linkage to LTC and Supportive Services<br>8. Interaction with Medicaid Eligibility Approval Process<br>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<br>2. Pre-screening for Medicaid programs<br>3. Facilitating Medicaid application<br>4. Assisting clients to utilize Medicaid services<br>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.<br>2. Medical service coordination.<br>3. Level of Care/Functional screen admin<br>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.

## Attachment H: Veterans Health Administration Opportunity for ADRCs

**Special Opportunity To Expand HCBS Access for Veterans**

### Summary

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA) has a long standing partnership with the U.S. Department of Health and Human Services (HHS) and partners with the Aging and Disability networks to provide Veteran Directed Home and Community Based Services (VD-HCBS). The VHA plans to build on the existing partnership with ACL by purchasing the services of ADRC Options Counselors to work with veterans and their families as they determine how to use their flexible HCBS service budgets to meet their LTSS needs, goals and preferences.

The VHA recognizes the ADRC Options Counseling Program as the front door to LTSS and will have estimated expenditures of up to $9 million each year over the project period across states who receive the "The Enhanced Aging and Disability Resource Center Options Counseling Program" Award. Flexible HCBS service budgets and the services of an ADRC Options Counselor will be offered, no matter if the Veteran chooses Veteran Directed HCBS or non-veteran directed HCBS. The VAMC will directly purchase Options Counseling from the ADRCs. Veterans may choose to self-direct their services or purchase traditional HCBS services.

This Attachment provides guidance to states interested in pursuing this "Special Opportunity to Expand HCBS Access for Veterans."

### Background

The VA's mission is to fulfill President Lincoln's promise "To care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's veterans. Last year approximately $6.3 billion was invested to provide LTSS. The number of veterans in need of LTSS is projected to increase commensurate with the number of veterans with service-connected disabilities. Much like the general population, veterans prefer to receive their care and services in the least restrictive setting, desire to be engaged in family and community life and value an option to direct their care and services including hiring family, friends and neighbors to provide HCBS. Anticipating the growing need for LTSS, the FY 2013 President's Budget, includes a proposed increase of the VA LTSS by $500 million to strategically expand access to both

institutional and non-institutional LTSS.[4] HCBS is a mandated benefit for all Veterans enrolled in the VA system, 38 CFR Part 17.38.

As of September 30, 2010 the total veteran population 17 years of age and older was 22.7[5] million. Of these veterans 40%[6] are age 65 or older while 1.4%[7] are under age 25. While the total number of veterans is decreasing, the number of veterans with a service-connected disability is increasing. A service-connected disability means the disability was a result of disease or injury incurred or aggravated during active military service. These disabilities are evaluated according to the Department of Veterans Affairs' (VA) Schedule for Rating Disabilities in 38 CFR Part 4. Since 1990 there has been a 46% increase in the number of veterans with a service connected disability.[8] In FY 2010 more than 3.2 million veterans or 14% of the total veteran population had a service connected disability.[9] Service-connected disability ratings are graduated based on the degree of the veteran's disability on a scale of 0 to 100% in increments of 10%. The growth in the number of veterans with a service-connected disability is concentrated among those rated 50% or higher.[10] The graph below by Dr. Stephen Kaye show that the number of community-resident veterans reported as needing help in 2 or more of the basic activities of daily living (ADL) is also increasing.[11]

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[4] VA 2013 Budget Fast Facts. http://www.va.gov/budget/docs/summary/Fy2013_Fast_Facts_VAs_Budget_Highlights.pdf

[5] US Department of Veterans Affairs, Office of the Actuary, Veteran Population Projections Model (VetPop), 2007, Table 5L.

[6] US Department of Veterans Affairs, Office of the Actuary, Veteran Population Projection Model (VetPop), 2007. Prepared by the National Center for Veterans Analysis and Statistics.

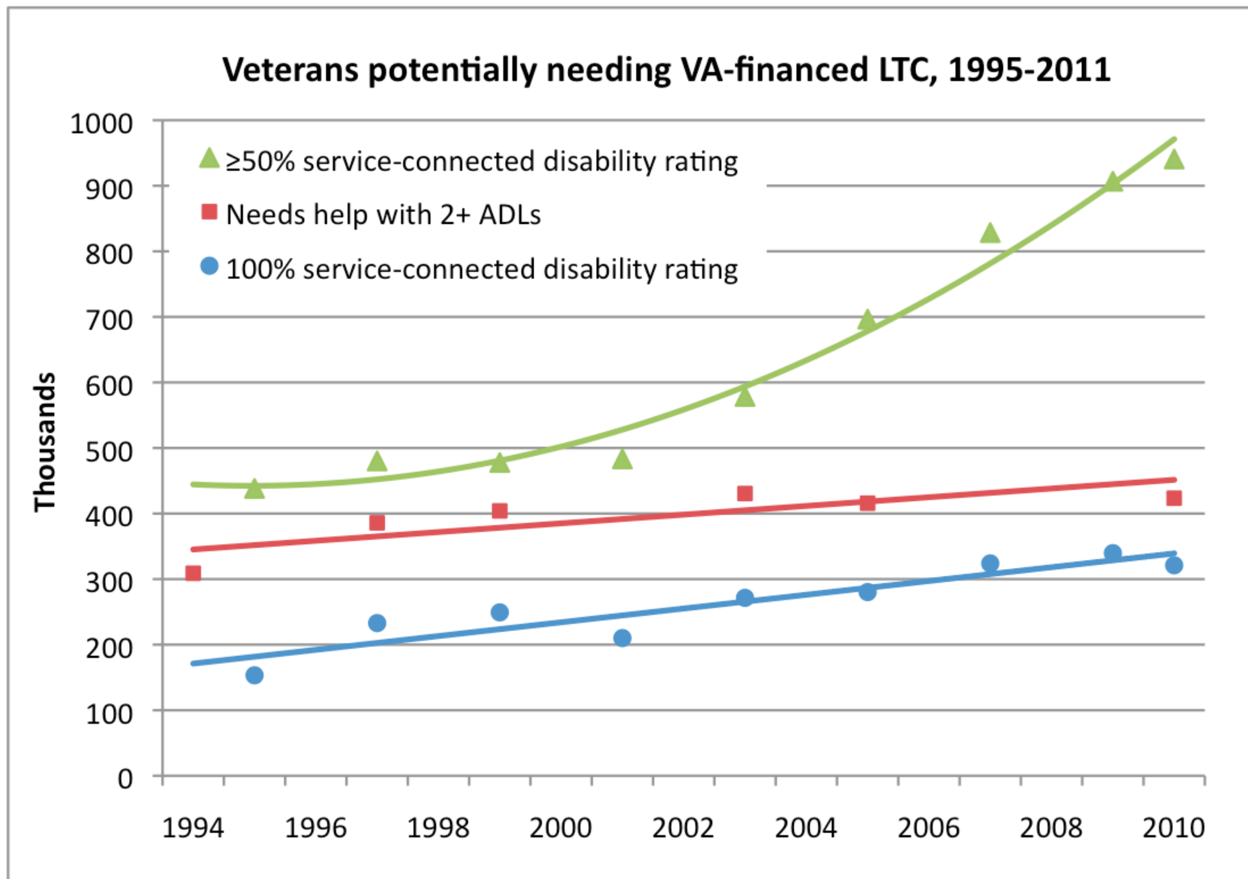
[7] Department of Veterans Affairs, Office of the Actuary, Veteran Population Projection Model (VetPop), 2007. Prepared by the National Center for Veterans Analysis and Statistics.

[8] Department of Veterans affairs, Veterans Benefits Administration Annual Benefits Reports, 1985-2010; Office of Policy & Planning, Office of the Actuary, Veteran Population Projection Model (VetPop), 2007. Prepared by the National Center for Veterans Analysis and Statistics.

[9] Department of Veterans affairs, Veterans Benefits Administration, Annual Benefits Reports, 1985 to 2010. Prepared by the National Center for Veterans Analysis and Statistics.

[10] Department of Veterans affairs, Veterans Benefits Administration Annual Benefits Reports, 1985-2010. Prepared by the National Center for Veterans Analysis and Statistics.

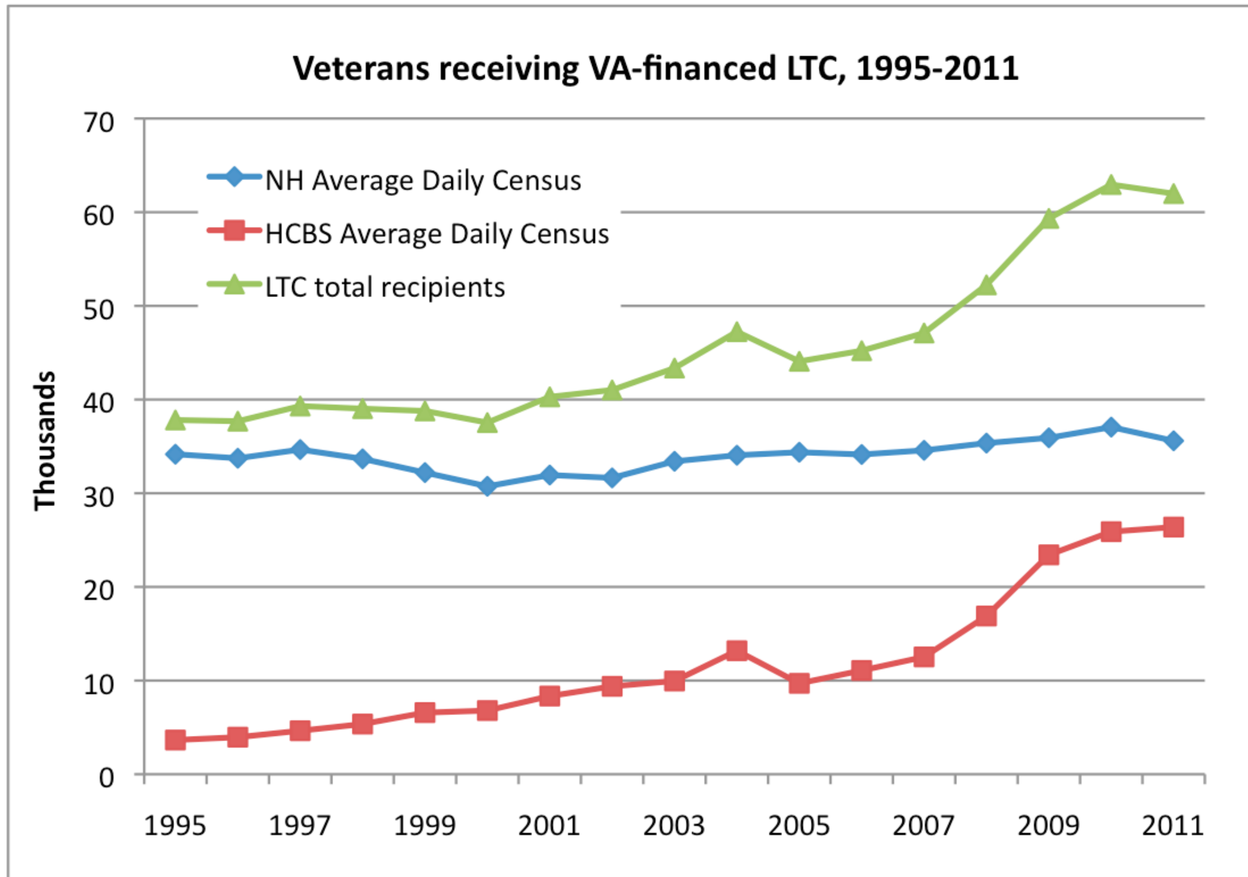
[11] H.Stephen Kaye, Ph.D., Center for Personal Assistance Services University of California San Francisco; PAS Center funded by National Institute on Disability & Rehabilitation Research. Feb 2012.




12

Last year more than 100,000 veterans received LTSS and approximately 60% were provided HCBS while 40% received their LTSS in a nursing home. From 1995 to 2011, the total number of veterans receiving LTSS has increased 64%.

[12] H.Stephen Kaye, Ph.D., Center for Personal Assistance Services University of California San Francisco; PAS Center funded by National Institute on Disability & Rehabilitation Research. Feb 2012.



[13]

From 2007-2011, VA's LTSS expenditures increased by $1.2 billion. This amount represented a 22% increase in total expenditures in LTSS. During this time period nursing home expenditures increased by $1 billion and HCBS expenditures increased by roughly $300 million. In 2011 HCBS expenditures represented 19% of total LTSS expenditures.

Another way to look at expenditures is by reviewing annual expenditure per LTSS recipient. Of note, throughout the period, per-resident nursing home expenditures were much greater than those for HCBS; in 2011, the ratio was 5.3 to 1. Despite the increasing per-resident nursing home expenditure, the total LTSS expenditure per veteran remains relatively steady, at roughly $80,000 in 2010 dollars, over the period because of increasing utilization of less-costly HCBS.[14]

[13] H.Stephen Kaye, Ph.D., Center for Personal Assistance Services University of California San Francisco; PAS Center funded by National Institute on Disability & Rehabilitation Research. Feb 2012.
[14] H.Stephen Kaye, Ph.D., Center for Personal Assistance Services University of California San Francisco; PAS Center funded by National Institute on Disability & Rehabilitation Research. Feb 2012.

The VHA is seeking to expand access to HCBS to honor veteran's preferences to remain engaged members of the community and to increase the numbers of veterans that may receive LTSS. The VHA has a long standing partnership with the ACL and partners with the Aging and Disability networks to provide Veteran Directed Home and Community Based Services (VD-HCBS). The VHA plans to build on the existing partnership with ACL by purchasing the services of NWD/ADRC Options Counselors to work with veterans and their families as they determine how to use their flexible HCBS service budgets to meet their LTSS needs, goals and preferences.

Over the last 4 years more than 38 VAMCs across 15 VISNs have been purchasing Options Counseling services via the VD-HCBS from 91 AAA/CIL/ADRCs. Options Counselor's work with veterans and their families to identify their functional needs, develop a service plan to meet those needs, activate the service plan and follow-up to assure the plan is working as the veteran envisioned. More than 17% of the individuals served through the VD-HCBS program are under 60, many having returned from current conflicts including Operation Iraqi Freedom, Operation Enduring Freedom and Operation New Dawn.

Starting in 2008, ACL has collaborated with the VHA to deliver a veteran-directed option to veterans in need of home and community based services. HHS, through the ACL, continues to work closely with VHA to provide an additional opportunity to SUAs and AAAs to serve veterans of all ages at risk of nursing home placement. ACL and VHA's long-range national vision is to have a long-term service and supports system that is person-centered, consumer-directed and helps people at risk of institutionalization to continue to live at home and be engaged in community life. The VHA will increase access to HCBS to serve the growing demand of veterans who desire home care and prefer independence at home over living in a nursing facility. Current research shows that on average, the Medicaid dollars that are required to support one adult in a nursing home are almost enough to support three adults with physical disabilities in the community.[15] As the need of veterans for LTSS continues to grow, increasing access to HCBS strategically through an ADRC is essential to meeting the current and future needs of veterans and their families.

**How Do I Apply?**

States interested in pursuing this additional opportunity will be required to submit the following as an Addendum to their ADRC application:

***I. Letters of Commitment*** from:

[15] Kassner E, Reinhard S, Fox-Grage W, Houser A, Accius J, Coleman B, et al. A balancing act: state long-term care reform [Internet].Washington (DC): AARP Public Policy Institute; 2008 Jul [cited 2011 Jan 25]. (Research Report).

1. Leadership at VAMC (e.g. CEO, CMO or CFO)
2. VISN Director
   - If there are multiple VISNs in your state wishing to participate please submit LOC's from each participating VISN.

***II. Approach***. Each applicant should describe the approach your state will take to develop and deliver VDHCBS services to Veterans statewide by the end of the 3 year project period.

Applicant should describe:

1. After receipt of VDHCBS funds how soon implementation will begin.
2. Any relationships, formal or otherwise, that exists at the state or local level between ADRCs and VAMCs.
3. Demonstrated experience in the delivery of a consumer directed program(s).
4. Any current relationship that exists between a state or local ADRC and an FMS vendor in the deliver VDHCBS.

Reviewers will look favorably upon applications that:

1. Include a Letter of Support from the State Office of Military and Veterans Affairs
2. Have minimal or no delay in the delivery of VDHCBS upon receipt of funds

VISN/VAMCs serving veterans in the state shall indicate their interest in applying for the VA HCBS Expansion Program via letters of commitment that are included with the state's application. VISNs/VAMCs will agree in the letters of commitment that they will use funds to purchase the ADRC Options Counseling Program and provide each veteran with a flexible HCBS budget. Similar to previous funding opportunities, the **VA HCBS Program application shall be made by including in the ADRC grant application letters of commitment from the VISNs/VAMCs that serve veterans living in the state.**

**Within 6 Months After Receipt of ADRC Options Counseling Award**

States receiving this funding opportunity and who select to participate in these joint VHA activities will work with their local ADRCs/VAMCs to submit the following project management information to ACL, CMS and VHA:

- Number of Veterans served through VDHCBS to Date: _________
  (as of __/__/____)
- Number of Veterans expected to be served through VDHCBS in Year 1: _____

- Number of Veterans expected to be served through VDHCBS in Year 2: _____
- Number of Veterans expected to be served through VDHCBS in Year 3: _____
- Number of Veterans expected to be served over 3 year project period _____ at a total estimated cost of $_____

**What is the VISN/VAMC and ADRC Options Counseling role in the delivery of the VA HCBS Expansion Program?**

For the selected States participating in this funding opportunity, the Designated State Agencies by the Office of the Governor will provide an Options Counseling program through ADRC sites. The VAMC will screen veterans that are eligible for HCBS and determine the case-mix category that is most appropriate based on the veterans functional needs. The VAMC will refer eligible veterans with a flexible HCBS service budget to the ADRC. Upon referral from their VAMC colleagues, the ADRC Options Counselors will conduct comprehensive person-centered assessments, work with the veteran and their family caregiver to develop HCBS service plans, provide consumer directed models of care when selected, work with the veteran to activate HCBS services and provide on-going options counseling to veterans and their family caregivers in partnership with their local VA Medical Center(s).

Options counseling enables individuals to understand the services available in their communities, evaluate the utility of these services, make informed decisions about the services that best meet their needs and preferences, and make the best use of their own personal and financial resources over time. Options Counseling also helps ensure that people receive services they choose, including streamlined access to services to ensure that an individual's service plan is activated. Options Counseling connects individuals to appropriate services using person-centered planning methods.

Options counseling involves self direction of services. Self direction enables access to services and supports that are controlled by the individual; self directed services are also a key requirement of the Older Americans Act of 1965 as Amended In 2006 (Public Law 109-365) (OAA). The OAA requires the Assistant Secretary for Aging to promote coordinated systems of care that enable individuals to receive long term services and supports in home and community-based settings "in a manner responsive to the needs and preferences of older individuals and their family caregivers." Flexible spending accounts, which are integral to successful self direction, are a vehicle by which individuals directly hire their workers and directly purchase goods and services. A large, randomized-controlled trial of self direction provided evidence of the efficacy of this approach. Results included greater

satisfaction with quality of services, satisfaction with quality of life, sense of empowerment, and decreased unmet needs.[16]

Based on the number of veterans that will be referred to the ADRC Options Counselors, the local VA Medical Centers will provide funding to the ADRCs so that Options Counselors are available and ready to serve veterans as they are referred by the VAMC. The estimated monthly budget for HCBS services for each enrolled veteran will be supported by ongoing VA HCBS funding. Similar to the VD-HCBS program, the VAMC will pay for both the VA HCBS Administrative component and the HCBS services. The ADRC Options Counseling program will submit bills to the VAMC on a monthly basis. If the veteran chooses to receive traditional HCBS services, the HCBS service agencies selected by the veteran will bill the ADRC OC program for HCBS services provided. If the veteran chooses VD-HCBS, the ADRC will provide the funds for the flexible service budget and bill the VA for both the VD-HCBS Administrative component and the authorized services at the end of each month.

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[16] Brown, R et al: 2005. Cash and Counseling: Improving the Lives of Medicaid Beneficiaries Who Need Personal Care or HCBS Princeton NJ: Mathematica Policy Research Inc

# Attachment I: Person-Centered Assessment and Planning

## ADRC Options Counseling Role in Person-Centered Assessment and Planning

### Overview and Background

ADRCs serve as the front door to LTSS for all populations and payors. Options Counselors have a critical role in the front door as the individuals who provide service and planning assistance, assist individuals in accessing services, and provide follow up. To meet the requirements of this funding opportunity these activities must be carried out using a comprehensive Person-Centered Planning (PCP) approach. This approach recognizes the dignity of the individual, and enables individuals to make service and support choices that optimally meet their needs and preferences, include their personal and community supports, maximize independence, and use public and private financial resources most efficiently.

With PCP, the Options Counselor recognizes that the process needs to be directed by the individual with long-term support needs, and may also include a representative whom the individual has freely chosen. The PCP approach identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual. The process enables and assists the individual to identify and access a personalized mix of paid and non-paid services. The individual's personally-defined outcomes, preferred methods for achieving them, training supports, therapies, treatments, and other services needed to achieve those outcomes become part of a written service and support plan.

ADRCs must have, or develop/train, options counselors who understand and use a PCP approach. This may require competency based training to insure that options counselors have an in-depth understanding of all aspects of person-centered planning, have comprehensive knowledge about the service delivery system including participant directed programs, and the ability to convey this information, to individuals, and their representative(s) and/or family members, in a way that enables them to make informed choices about the most appropriate services and supports.

In addition, for Options Counselors to fully integrate a PCP process in their work, ADRCs must incorporate PCP principles in their policy, mission/vision statements, and operations documents. And, staff at all levels must have a consistent understanding of PCP principles, process and implementation.

### Potential funding Streams

It is imperative that sustainable funding streams be made available for training and person centered-planning development. Funding for person-centered planning could include a number of federal and state sources. Federal sources include a number of Medicaid authorities (subject to eligibility rules) such as the Medicaid State Plan, 1915(c) waivers, various managed care authorities, and a number of Affordable Care Act provisions, including Health Homes, and Community First Choice. Existing programs are also important sources of potential funding. These include mental health block grants, Older Americans Act funding, Veterans Administration funds, and the Money Follows the Person program.

States should carefully consider the strengths and weaknesses of various funding steams and should consider combining funding around various components of the planning process and/or as way to ensure continuity across eligibility requirements for various programs. For instance, mental health block grant funding could be used to develop an initial plan while a person with mental health needs are waiting for an eligibility determination from Medicaid, at which point Medicaid could potentially pick the funding. Ideally in this scenario, the person developing the plan would be enrolled as a provider in both funding streams to foster continuity in the planning development process.

**ADRC Person Flow Chart**

The Options Counseling Program Person flow chart in the funding opportunity description illustrates the steps in the person-centered needs assessments and planning process. It shows that the initial screen informs the comprehensive person-centered needs assessment and begins development of the LTSS plan. The person-centered planning process includes a review of private resources and assessment of functional and financial eligibility for public programs. The plan is completed after the final decisions have been made and the individual's plan is activated. While arguably a person-centered plan can be developed at any time, it is ideal to develop a plan once service funding is clear. Also, depending on the needs of the individual and the resources available to him or her, the person-centered plan development process can be significantly resource intensive, particularly for the first plan. The person-centered plan is also the basis for service utilization review as well as follow up of identified outcomes, satisfaction and quality.

**Components of PCP to be included in Options Counseling Programs in ADRCs**

ADRCs must have Options Counselors who include the process and person-centered plan elements listed below in the overall assessment and planning process.

Process elements include the following:

- Individuals have control over who is included in planning process, as well as the authority to request a meeting and revise the plan.
- Individuals are equal partner in deciding when and where meetings are held.
- Information provided must be in language and/or formats that enable the individual to understand and make informed decisions about options.
- A strength-based approach to identifying the positive attributes of the person must be followed and an assessment of strengths (functional, cognitive, emotional) and needs must be conducted.
- Personal preferences must be solicited and used to help develop goals, and the services and support needs in a culturally appropriate manner.
- There must be mechanisms to minimize conflict of interests in the facilitation and development of the plan.
- Whenever possible a person must be offered the full range of services and supports available to support achievement of goals.
- The person must have decision making authority over which of the available services and supports to participate in and which of the available providers to work with.

PCP elements include the following:

- The plan must be prepared in person-first singular language and be comprehensible by the person and/or representative.
- In order to be strength based, the positive attributes of the person must be documented at the beginning of the plan.
- The plan must identify risks and the measures taken to reduce risks without restricting the ability to achieve goals.
- Goals must be documented in the person's and/or representatives own words, with clarity about the amount, duration, and scope of services and supports that will be provided to assist the person in achieving them.
- The specific person and/or provider agency providing services and supports must be documented.
- Other non-paid supports and items needed to achieve the goal must be documented. The plan must include the signatures of all people with responsibility for its implementation including the individual and/or representative, and a timeline for review.
- The plan must identify the individual and/or entity responsible for monitoring the plan and everyone involved (including the participant) must receive a copy of the plan.
- The plan must be directly integrated into self-direction when applicable and an emergency back-up plan must be documented when needed.

- The person-centered plan must document the supports that would be necessary to fully meet the quality of life domain standards.
- A copy of the plan must be provided to the individual and their representative(s).

PCP Follow Up include:

- Progress toward achieving the goals identified in the plan are monitored and followed up on.
- There are mechanisms to ensure that the paid and unpaid services and supports are delivered,
- The plan is reviewed according to the established timeline
- There is a feedback mechanism for the individual to report on progress, issues and problems.

**References or links to additional relevant information**

Here are a several links that may be helpful in developing the person-centered planning process for various populations:

Essential Lifestyle Planning
http://www.elpnet.net/elp3.html

Includes a collection of tools for person-centered planning.
http://www.nhcebis.seresc.net/person_centered_planning

Making Action Plans (MAPS) and Planning Alternative Tomorrows with Hope (PATH)
http://www.inclusion.com/path.html

Wellness Recovery Action Planning (WRAP)
http://www.mentalhealthrecovery.com/

Psychiatric Advance Directives
http://www.nrc-pad.org/

Shared Decision Making
http://store.samhsa.gov/product/Shared-Decision-Making-in-Mental-Health-Care/SMA09-4371

# Attachment J: Draft National Options Counseling Standards

**May 2012**

## Introduction

In 2010, the AoA, now the ACL, funded ADRC programs in 19 states to work with AoA and each other in a collaborative process to develop national minimum standards. These standards guide how Options Counseling is delivered, who delivers it, under what circumstances, and how outcomes are tracked across the ADRC network. Through the grant, states will also design, implement and test draft standards for Options Counseling.

Beginning in November 2010, ACL has met monthly with Options Counseling grantee states via conference call to discuss elements of minimum national standards and lay out a vision for options counseling. ACL has also sought input from federal partners, technical assistance providers and representatives from aging and disability services networks to ensure the standards are relevant to and applicable across all populations. These conversations have produced the following draft standards for Options Counseling based on the definition of Options Counseling proposed by the National Association of States United for Aging and Disabilities in 2007.[17]

This is the third version of the draft standards and incorporates feedback from grantee draft standards and ACL's calls with grantee states to discuss their standards. Please note that this language is a **draft;** the standards will continue to evolve as ACL continues discussions with stakeholders at the federal, state and local levels.

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## ACL Vision for Options Counseling

[17] Long-Term Support Options Counseling: Decision Support in Aging and Disability Resource Centers, NASUAD, 2007 online at: www.adrc-tae.org/tiki-download_file.php?fileId=29256

The primary goals of Options Counseling are to facilitate informed decision-making about LTSS and serve a key role in the streamlined access to supports. It represents a critical service of ADRCs as they help provide a clear pathway for individuals to access LTSS. It supports the broader system goals of rebalancing LTSS and helps to prevent or delay premature institutionalization by offering options to help individuals spend resources wisely in the community. Developing a formal Options Counseling program will facilitate some of the structural changes necessary to receive the enhanced FMAP available through CMS initiatives such as the Balancing Incentive Program.[18]

Some individuals may only need information about LTSS, but many need options counseling for the following reasons:

- A tremendous amount of information about LTSS is available on-line, but it can be complex, contradictory, and confusing;
- Individuals and families may want or need additional support interpreting information and weighing the pros and cons of their different decisions about LTSS;
- Few people plan ahead for long-term supports; and
- Institutional placements often occur without consideration of available community-based options.
- Accessing public supports can become a complex process where navigation assistance is needed

ACL views Options Counseling as both a philosophy underpinning how ADRCs interact with individuals, as well as a process that ADRC staff will follow to support individuals and families to consider their options and access the right services and supports at the right time. Options Counseling should:

- Be available to anyone contacting the ADRC network;
- Be person-centered and directed by the individual;
- Support people of all income levels to make informed decisions;
- Be delivered in a timely and/or expedited manner when the need for a short-time frame is presented;
- Serve as comprehensive and streamlined process by which people learn about and are connected to immediate and on-going support as needed or requested;
- Be the service that brings the larger aging and disability networks closer together; and
- Be valued by a large set of potential funders and stakeholders.

[18] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html get correct link here

Options Counseling plays a pivotal role in supporting many federal initiatives and programs that encourage community living such as Veterans-Directed Home and Community-Based Services (VD-HCBS), participant-directed programs, care transitions interventions, and Medicaid waiver and other programs such as Money Follows the Person. Some of these programs represent potential future funding sources to sustain OC within ADRC networks.

## Goals of the Standards

The main goal of these standards is to provide a clear definition of Options Counseling (OC) and a framework for which the aging and disability organizations involved in ADRC networks can build OC capacity. The specific goals of these standards include:

- Improving the consistency and quality of OC provided by ADRC networks including capacity to work with individuals who have private resources to spend on LTSS as well as those who may qualify for publically funded programs;
- Providing a basis to determine the impact of OC on the LTSS system;
- Developing the groundwork for training and continuing education materials and programs related to OC; and
- Preparing the aging and disability networks to meet the demands of the next several decades as a growing aging and disability population base seeks assistance in navigating LTSS.

## Definitions

**Individual –** Organizations may have different terms for individuals served such as client, consumer, or participant. The individual is the person seeking Options Counseling. The individual may choose to include a representative, another person, or more than one person, to participate in the process.

**Caregiver** - A family member, partner, friend, or neighbor who supports an individual. Caregivers may also be the individuals seeking Options Counseling for their own supports. They do not make decisions for the individuals they are supporting.

**Representative –** A family member, friend or other person who is chosen by the individual seeking options counseling, to assist with decisions or to serve as the primary decision maker. This person may also be a guardian or an otherwise legally authorized to represent the individual.

**Long-Term Services and Supports –**Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) provided to older people and other adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more.[19] These are sometimes referred to as Long Term Resources or simply Long Term Supports.

**Decision Support –** A process of examining pros and cons of various options. It may include information and education, but goes beyond both of these to support an individual as he or she weighs options. It includes exploration of an individual's perceptions about the pros and cons and dialogue about how those perceptions influence potential decisions. The use of planning tools is a common method to assist the individual in the decision making process.

**Person-Centered Planning Approach (PCP) –** A process that is driven by the person with long-term support needs, and may also include a representative whom the person has freely chosen or is legally authorized. The PCP approach identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual. Agency workers' (options counselors, support brokers, and others) role in the PCP process is to enable and assist the person to identify and access a personalized mix of paid and non-paid services. The individual's personally-defined outcomes, preferred methods for achieving them, training supports, therapies, treatments, and other services needed to achieve those outcomes become part of a written LTSS plan.[20]

**Action Plan –** A plan outlining goals, action steps, timelines, resources needed, responsible parties, and referrals made in the Options Counseling process that are needed by the individual and/or counselor to attain supports that meet the goals and preferences of the individual. This plan is time-limited and is directed and developed by the individual with support from the Options Counselor as needed. A copy of the action steps plan may be kept by both the Options Counselor and the individual as both may have action items to complete, and it may serve as a guide for the Options Counselor in following up with the individual as well. The action steps plan is the deliverable after Options Counseling process is complete. It outlines the steps individual will take to address the presenting goal or intention. It is driven by the individual and for the individual.

[19] Adapted from LTSS Scorecard Definition http://www.longtermscorecard.org/~/media/Files/Scorecard%20site/Report/AARP_Reinhard_Realizing_Exp_LTSS_Scorecard_REPORT_WEB_v4.pdf
[20] Adapted from 2402a interagency HHS work group

**LTSS plan –**After a person is enrolled in publically funded long-term services and supports program (for example, Medicaid waiver), this plan outlines the frequency and type of services and supports (both formal and informal) to meet personal goals. It is used as a referral channel and to activate service and also as quality assurance plan to ensure goals and preferences are met. Options counselors can assist the individual in developing this plan but not all states have Options Counselors serving in this role.

**Participant-Directed Services –** Publically funded LTSS that are planned, budgeted and directly controlled by an individual (with help of representatives, if desired) based on the individual's preferences, strengths, and needs. Participant-directed services maximize independence and the ability to live in the setting of the individual's choice.

## Standards for Options Counseling

### I. Service Definition, Population, and Outreach

***Standard 1.1:*** **Definition of Options Counseling**
ADRC Options Counseling is an interactive process where individuals receive guidance in their deliberations to make informed choices about long-term supports. The process is directed by the individual and may include others that the person chooses or those that are legally authorized to represent the individual. Options Counseling includes the following steps: 1) A personal interview to discover strengths, values, and preferences of the individual and the utilization of screenings for public programs, 2) a facilitated decision support process which explores resources and service options and supports the individual in weighing pros and cons, 3) developing action steps toward a goal or a long term support plan and assistance in applying for and accessing support options when requested, and 4) quality assurance and follow-up to ensure supports and decisions are working for the individual. Options Counseling is for persons of all income levels but is targeted for persons with the most immediate concerns, such as those at greatest risk for institutionalization.

***National Interpretive Guidance***

1. **A personal interview,** which includes a "one-on-one" conversation with the individual, his or her representative- and their family members as appropriate – that would facilitate an initial screen to determine if the person needs LTSS. If so, then a comprehensive person-centered planning process starts to occur to identify in the individual's strengths, values, and preferences. This process will include the identification of all current

supports, both formal and informal, and incorporate as appropriate the use of screening and assessment tools that may be required by various programs.

2. **A facilitated decision-support process** that helps individuals and their families weigh the pros/cons of various options, including exploration of self-directed options where individuals are empowered to hire, fire, and pay for services and supports through an individual budgeting process, and leads to:
   - Identification of desired and available options (including informal supports, emergency supports, funding sources, etc.).
   - Assisting individuals and families in determining how best to pay for and arrange the delivery of services, including helping individuals to assess sufficiency of their own resources, and their eligibility for public programs, including, if appropriate, Medicaid, Medicare, and Veterans' benefits;
3. **Development of a LTSS service plan and connecting people to the services and supports they need**:
   - For those not participating in public programs, the ADRC counselor helps the individual develop a person-centered plan that describes 1) the immediate next steps to be taken in the decision-making process, and 2) the mix of informal supports, community resources, and privately funded services an individual elects to use based on his or her individual preferences and needs;
   - For those using a public option such as Medicaid, Medicare and/or Veterans programs, the process includes:
     - Facilitating eligibility and enrollment
     - Assistance in developing a person-centered service plan
     - Facilitating support/service activation including choice of traditional of self-directed options
     - Arranging for fiscal intermediary service when an individual chooses self-direction, and assisting with choice of support broker/agent

4. **Quality Assurance & Follow-up** to:
   A. Assure the supports meet the individual's preferences
   B. Gather and act on individual feedback on services and the delivery systems
   C. Serve as a navigator to ensure that the needed services are activated, providing on-going follow-up to monitor quality, and assist with changes in the services plan as necessary
   - Input data into reporting systems that monitors program performance, customer satisfaction, customer trends, and customer preferences

- Use CQI process to ensure program success and resolution of issues and is part of a larger long term support system quality assurance process

If the Options Counseling program does not include assistance with applications for services, employment assistance, benefits counseling, futures planning, mobility assistance, and or support accessing participant-directed services, when available, there should be a mechanism in place to ensure the individual is connected to someone who can provide support in these areas.

The length of the Options Counseling process will vary based on a variety of factors, including: the pace the individual wants to take, the resources allocated by funding source, the program design of the particular ADRC/NWD/SEP process, as examples. The intention of the process is that the individual can return to the Options Counselor at various times for guidance and/or assistance obtaining long term supports. The person may obtain immediate assistance in a crisis situation or may be able to take the process more slowly based on the individual's current situation.

***Standard 1.2:*** **Target Populations: Who Should Receive Options Counseling?**
Options Counseling is available to all persons with a disability, older adults or caregivers who request or require long term support services for a current need and/or persons of all incomes and assets who are planning for their future long term support service needs.

***National Interpretive Guidance***

- While the broad service population is the ideal, if ADRCs have limited funds, it is suggested that ADRCs consider targeting this service to the following categories of individuals due to the more immediate nature of their need for Options Counseling:
    - individuals transitioning from hospitals,
    - individual transitioning from skilled nursing facilities or extended care facilities, and
    - individuals at high risk for institutionalization.
- ADRCs should strive to use the latest research and data available to identify the populations that might benefit the most from Options Counseling. States should assure that the targeting criteria is consistent with its existing plans for long-term support reforms which may include coordination with the States' Olmstead committee and plans developed by the Statewide Independent Living Council, State Unit on Aging, State Medicaid Agency, State

Department of Veterans Affairs and other state agencies or statewide organizations that support individuals with disabilities.

- In some cases, caregivers may be the individuals seeking assistance with decision-making. Options Counseling should be offered to caregivers to assist in determining their desire for caregiver support which might include: communication strategies, ways to reduce caregiver stress, and the importance of individual self-determination. A core tenet of an ADRC is a commitment to break down barriers to assistance and support. It is essential to support caregivers while also protecting the rights of individuals to self-determine. Ideally, the ADRC network is tapping funding for supporting caregivers, providing options counseling, getting individuals connected to the supports and services they desire in a seamless and unified way so that the caregiver or individual being supported does not have to fit strict or particular program eligibility guidelines to obtain assistance. In the best processes, State leadership is working collaboratively with local ADRC sites to provide Options Counseling in an integrated and holistic way.

***Standard 1.3:* Marketing/Outreach**

Each ADRC will have in place a written plan to promote awareness of Options Counseling to individuals and community providers. The Options Counseling marketing/outreach plan may be incorporated into the overall ADRC marketing/outreach plan.[21]

## II. Getting to Options Counseling

***Standard 2.1:* Initiation/Referral Protocols for Options Counseling**

Options Counseling is an essential piece of the No Wrong Door/Single Entry Point Process. Each ADRC will have in place a mechanism for receiving initial inquiries/referrals regarding or contacts that may lead to the initiation of the Options Counseling process. Each ADRC will have in place a uniform process regarding the initial contact/intake and determination of need or trigger for options counseling that is utilized at all locations and with all partners.

***National Interpretive Guidance***

- To facilitate a uniform initiation process, it is recommended that a formal protocol and training be established for staff and referral

[21] For more information about what should be included in an ADRC Marketing and Outreach plan see ACL ADRC Fully Functioning ADRC document. http://www.adrc-tae.org/tiki-download_file.php?fileId=29619

partners (e.g., I and R/A specialists, 211 specialists, SHIP counselors, benefits counselors, others as identified). Training would include recognizing when someone might benefit from Options Counseling (for examples see list below), informing the person that participation in Options Counseling is voluntary, and the procedures for connecting the individual with an options counselor, when referral is necessary.

***Standard 2.2:* Delivery Setting/Mode**

Every attempt should be made to deliver Options Counseling in the setting and by the method desired by the individual.

***National Interpretive Guidance***

Settings may include the individual's place of residence, an agency, a nursing home, hospital, rehabilitation center, medical practice, or even non-traditional settings of the individual's choosing. Modes of service delivery may include in person, by phone, by e-mail, by video conferencing technology, or other electronic method. Whenever possible an in-person meeting with the individual is preferred. In-home visits are a particularly useful method to help identify the values and preferences of the individual as well as actions needed to maintain independence. The ADRC may wish to establish guidance for staff on when to offer an in-person meeting or home visit.

## III. Components of Options Counseling

***Standard 3.1* Personal Interview**

A key component of effective options counseling is setting a welcoming tone through a person-centered dialogue to learn about the individual's values, strengths, preferences, and concerns. This discussion is a process of discovering factors important to him or her to assist the person in exploring options and developing an action plan or long term support plan. It is important that the individual has to "tell their story" only once. Pertinent information obtained through the interview and required assessments need to be recorded by the person performing Options Counseling and shared as necessary with the individual's consent. The individual may choose to have a family member, caregiver, support person, or advocate participate with them in the process.

***National Interpretive Guidance***

- This conversation may occur once or over a series of interactions.

- The conversation should touch on key areas that would influence available options relevant to the individual's situation including strengths, physical, emotional, social, financial, and functional aspects. Based on the state and local ADRC mechanism for service delivery and the overall model of options counseling, the Options Counselor will need to obtain specific, pertinent information to assist in the application for publically funded services and supports.
- The conversation should occur in a timely manner and meet the schedule and needs of the individual.
- Options Counseling is person-centered and the individual controls the planning process, which includes: selection of goals; when and where meetings are held; who is a part of the planning meetings; the topics to be/not to be discussed; and personal decisions about supports and services.

***Standard 3.2:*** **Exploring Options/Planning**

Options Counseling includes the exploration of resources so individuals can choose what is right for them to assist with current or future long term services and supports. Resources may include informal support, privately funded services, publically funded services and benefits, among others. A tailored list of resources that the individual identifies as helpful for him or her to live independently in their community should be offered in a timeframe that gets the information to them when they need it to make decisions.

***National Interpretive Guidance***

- OC should include discussion of available options without the personal bias of the Options Counselor.
- Organizations providing OC should have policies and procedures in place to remain free of conflicts of interest. As part of the OC process, the options counselor will encourage the individual to explore informal supports that might be available such as support from community groups, places of worship, neighbors, and friends.
- The Options Counseling process will include discussion of publically-funded LTSS as well as private LTSS including the approximate cost of services.
- Options Counselors also should facilitate futures planning by talking with individuals about options for services and supports should they be needed in the future.
- To assist in the exploration of available options, it is recommended that Options Counselors assist individuals, when necessary, in making

appropriate connections to persons that have specific training in available benefits and expertise related to the persons options (such as SHIP counselors, financial, employment, mobility assistance, etc..

***Standard 3.3:*** **Decision Support**

In addition to discussing and sharing information about available resources, Options Counseling assists the person in evaluating various pathways, including the pros/cons of specific options.

***National Interpretive Guidance***

Decision support is best performed by utilizing specific decision support tools, decision support processes, and decision support techniques, such as motivational interviewing and person- centered planning, and person-centered tools such as preferences maps, places maps, mind maps, evaluating options tools, and shaping outcomes tools. *(Insert references to these tools)*

***Standard 3.4:*** **Collaboration with Individual to Develop Action Steps or Long Term Support Plan**

Another component of the options counseling process is offering to assist the person in developing his or her personal written plan of action. The written plan serves as a guide for the individual for future work and/or steps necessary to achieve goals or obtain LTSS that are important to the person in maintaining independence.

***National Interpretive Guidance***

While the ultimate pace of the process is determined by the individual, funding sources may mandate certain time frames for completion of the plan. It is recommended that ADRCs position Options Counseling within a framework that will flexibly meet the needs of the individual while taking advantage of possible funding sources. The best written plans are developed to the greatest extent possible by the individual with assistance as necessary. It is important for the plan to be shared by the individual with others as desired, as well as retained in a file or electronically by the Options Counselor to use in following up

***Standard 3.5:*** **Access to Community Supports**

In addition decision support, Options Counselors will also provide assistance as requested by the individual to access or coordinate chosen services and supports. This support could be short or long process depending on the direction from the individual, degree of urgency expressed by the individual in meeting his

or her goals, or availability of funding to provide such support. If this function is not performed directly by the Options Counselor, the ADRC should have appropriate referral protocols in place to support individuals in accessing this support from other sources. Options Counseling is part of a uniform process across the state that streamlines eligibility and access to public programs.

Related to eligibility for public programs, Options Counselors may be involved in independent evaluation, independent assessment, the support plan, and care coordination. To assure conflict free delivery, an Options Counseling program should ensure that the decision support and eligibility determination functions are separate from the provision of services and supports selected by the individual.[22]

***National Interpretive Guidance***

- Connection to community supports may include the following components:
  - providing or coordinating eligibility determination;
  - assisting as services and supports are arranged/scheduled (e.g. serving as a support broker in a participant directed program); and/or
  - accessing resources in order to return to the community from an institution or hospital (e.g. transition coaching).
- The ADRC network's capacity to provide on-going support to individuals may vary depending on availability of funding to support OC. ADRCs may want to develop this capacity to take advantage of a broad range of funding sources that support independent living in the community.

***Standard 3.6:*** **Follow-up**

Follow-up is an essential component of Options Counseling to be offered to each individual. At this point the Options Counselor learns from the individual what progress towards goals and steps in the action plan has occurred. Any barriers to implementing the action plan can be discussed and the Options Counselor and individual can strategize about alternatives. Organizations offering Options Counseling should have standards for follow-up including time-frames and procedures.

[22] Insert link for additional information.

***National Interpretive Guidance***

- Follow-up may be conducted in person, by phone, or electronically as resources allow and the individual prefers.
- The individual's action steps plan should guide the time-frame for follow-up, but following up one month after OC process is a general guideline.
- Follow-up allows:
  - the individual to clarify questions concerning his or her plan,
  - the individual to receive assistance from the Options Counselor regarding the application and eligibility processes, if requested,
  - the individual the opportunity to request assistance regarding the implementation of LTSS, and
  - the individual and the ADRC to evaluate the usefulness of the service, such as barriers encountered in achieving his or her goal or whether the goals were met.

## IV. Staffing

***Standard 4.1:*** **Staffing Structure**

States and local ADRCs will determine a staffing structure for Options Counseling.

***National Interpretive Guidance***

- Options Counseling is preferably provided by one Options Counselor who supports the individual through the entire decision making process and follows up with the individual to see what decisions are working.
- Rapport-building is a critical component of Options Counseling.
- Options Counselors may be hired as new staff to perform Options Counseling, or ADRCs may choose to train existing staff from various departments and programs such as I & R/A, peer counselors, service coordinators, independent living skills trainers, case managers, front-line staff, transition coaches, or support brokers for participant-directed programs, as examples.
- ADRCs may choose to have Options Counselors provide Options Counseling as their only job responsibility, or ADRCs may organize their staffing structure that optimizes existing staff who serve in "blended roles" within the ADRC. It is at the discretion of the ADRC to determine what staffing structure will work best based upon their agency and organizational capacity and target population.
- The role of the Options Counselor and specialized skill set they bring in facilitating decision support may be valuable to other LTSS programs and

initiatives such as care transitions, MFP, and VDHCBS. ADRCs may choose to organize their staffing structure in a way that builds the core competencies of their Options Counselors to support these other initiatives, or to hire specialized staff who are trained in the Options Counseling skill set but work only in their role as a care transition coach, or a MFP transition coordinator. It is up to the ADRC to determine what capacity they have to meet the needs of individuals and the programs they have responsibility for administering.

***Standard 4.2:* Staff Education Work Experience**

State and local ADRCs will set minimum qualifications for education and/or work experience to perform Options Counseling consistent with state and local requirements. Options Counselor specific requirements include competencies in the domains of decision support, person-centered planning, cultural competency, communication, participant direction, and quality. [23]

***National Interpretive Guidance***

Given the complexity of the work and the level of skill needed it should be noted that Options Counseling is not considered an entry level position. Experience with the competency domains listed above should be strongly considered. Generally, a bachelor's degree in a human services related field would be minimum qualifications but states and localities may consider the replacement of experience and training for the degree requirement. States and local ADRCs may also include certifications – such as Certified Information and Referral Specialist (CIRS).

***Standard 4.3:* Staff Training *(This section will be enhanced as AoA Core Competency work evolves along the domains of decision support, person-centered planning, cultural competency, communication, participant direction, and quality.)***

All persons performing Options Counseling shall receive initial training. Each ADRC will have a staff development program in place. All persons performing Options Counseling should receive initial and ongoing training in the following areas:

- Physical and emotional aspects of aging and disability including
- Working with individuals with cognitive impairments and their caregivers,
- Vision for ADRCs and Options Counseling,

[23] Reference detailed OC Competencies when complete and public

- Decision support strategies (e.g. person-centered planning , motivational interviewing, relationship centered practice),
- Communication techniques for working with individuals and groups including use of adaptive and interpretive communication devices,
- Cultural competence,
- Information on available programs and resources (both public and private) including options to self-direct services and supports in publically funded programs,
- Documentation and follow-up protocols and requirements as established by the state and local ADRC.

Training plans are required to best work with many individuals, including:

- People with Alzheimer’s Disease or other types of dementia
- People with cognitive impairments, including traumatic brain injury
- People with visual impairments
- People who are hard of hearing or who are deaf
- People with intellectual and developmental disabilities
- People with physical disabilities
- People with mental health diagnoses
- People with cultural and ethnic backgrounds different from the Options Counselor
- Any person likely to use Options Counseling

***Standard 4.4*: Supervisor/Manager Training, Skills, Policy Maintenance**

State and local ADRCs will set minimum qualifications for Options Counseling supervisors consistent with State and local requirements. Options Counseling supervisors shall receive initial training in the topic areas identified in Standard 4.3. An on-going development program specifically for Options Counseling supervisors shall also be in place.

***National Interpretive Guidance***

Supervisors should possess the experience or educational training to oversee staff development, program management, program planning, policy/procedural maintenance, and program evaluation. Generally, a bachelor’s degree in a human services related field would be minimum qualifications plus three to five years of direct service and/or management experience. A master’s degree may be preferred. States and localities may consider the replacement of experience and training for the degree requirement.

## V. Partnerships

### *Standard 5.1:* Key Partners

Partnerships are the foundation of successful Aging and Disability Resource Centers. Since Options Counseling is at the center of streamlining eligibility and access to federal, state, and local services, it is important to include key partners in the process. Key partners include but are not limited to:

- state and local representatives of the aging network including those managing Title VI grants under the Older Americans Act;
- state and local representatives of the disability network, including the intellectual and developmental disability network
- state and local representatives of the Medicaid agency,
- state and local representative of the State Health Insurance Assistance Programs,
- representatives of Benefits Outreach and Enrollment Centers, if present,
- state and local providers of Information and Referral; and
- state and local providers for other long term services and support counseling programs.

The list is not exhaustive and state and local ADRC planners are encouraged to include other partners as identified.

### *Standard 5.2:* Partnership Roles

In addition to the identification of key partners, the ADRC will establish an overall strategy for the implementation of Options Counseling with key partners.

#### *National Interpretive Guidance*

For ADRCs in general and Options Counseling in particular to operate in a seamless manner, it is necessary that an overarching strategy be implemented with key partners. A process for including all partners and coming to agreements regarding roles is essential. Best practice indicates that leadership must be demonstrated at the highest levels to develop protocols (and written policies and procedures, Memoranda of Understandings, etc.) for a seamless and efficient system for the individual utilizing services.

## VI. Continuous Quality Improvement, Evaluation and Outcomes

### *Standard 6.1:* Documentation

Each ADRC will maintain a system to document unduplicated individuals receiving Options Counseling. Documentation should at a minimum include: name of individual(s) receiving OC, statement of needs, values and preferences, options discussed, plan of action for options counselor as well as individual, and the amount of time spent with/ or on behalf of the person.

***National Interpretive Guidance***
While ideally the individual who wishes to receive Options Counseling will provide demographic information, Options Counseling may still be provided if the person wishes to remain anonymous. In such circumstances, the only data required to be documented is the count of the options counseling process, and the amount of time spent with the individual. Documentation is preferably in an electronic format.

***Standard 6.2:* IT System Capacity for Tracking OC Outcomes**
ADRCs will utilize secure information systems sufficient to track the outcomes of options counseling as established by the local ADRC. Local ADRCs should make reasonable effort to also track state and national outcomes.[24]

***Standard 6.3:* Quality Improvement plan linked to specific outcome measures.**
Each state will develop a quality improvement plan for Options Counseling that involves making improvements to operations based on evaluation and survey information. At a minimum, the plan will monitor individual satisfaction with options counseling such as assistance with informed decision making, effectiveness in linking people to home and community based services when requested by the individual, as well as tracking transition and diversion activities. Options Counseling also plays a role in the larger Quality Improvement process by providing information about gaps in the system as identified by the individual.

[24] For additional information on IT system capacity for ADRCs, please consult the ACL ADRC Fully Functioning Criteria http://www.adrc-tae.org/tiki-download_file.php?fileId=29619

## Attachment K: Elder Abuse Detection and Prevention

### Increasing ADRC Options Counseling Programs Role and Capacity

**Overview and Background**

Elder abuse is a substantial public health and human rights problem. Available prevalence data suggest that at least 10% (or 5 million) of older Americans experience abuse each year, and many of them experience it in multiple forms.[vi] In addition, data from Adult Protective Services agencies show an increasing trend in reports of elder abuse,[vii] even though additional studies show that elder abuse is vastly under-reported[viii],[ix]. A 2011 study found that only one in 23.5 cases of abuse were reported to any agency; only one in 44 cases of financial exploitation were reported, and only one in 57 cases of neglect were reported.[x]

On average, older people have more chronic diseases and access the health care system at higher rates than other age groups. Older adults who are victims of violence have additional health care problems and higher premature mortality rates than non-victims. Older victims of even modest forms of abuse have dramatically (300%) higher morbidity and mortality rates than non-abused older people.[xi] Research has also demonstrated that older adults who are victims of violence have more health care problems than other older adults, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems.[xii] In addition, victims of elder abuse have significantly higher levels of psychological distress and lower perceived self-efficacy than older adults who have not been victimized.[xiii] As a consequence, not surprisingly they also incur higher health care expenditures than non-victims will.

Considering these factors together along with data that associated elder maltreatment with an increased risk for nursing home placement[xiv], and we are faced with a compelling argument for the ADRC Options Counseling Program to increase awareness and capacity to serve persons of elder abuse, neglect, and exploitation.

With this program announcement, states are encouraged to propose an approach within their Options Counseling protocols and procedures to increase the capacity of their ADRC program to detect and prevent elder abuse in at least one ADRC.

**Promising ADRC Practices in States**

## New Mexico

New Mexico's ADRC and APS program are administered by the NM Aging and Long-Term Services Department. The ADRC administers the intake portion of the APS program and is a key part of the state's 24/7 coverage and system of safety for New Mexico's most vulnerable populations. State employees operate the ADRC that serves the entire state out of a call center in Santa Fe. State staff dedicated to conducting intake for APS are co-located with other ADRC staff including resource coordinators (options counselors).

Both the APS staff and the resource coordinators at the ADRC are trained to screen callers for situations of neglect or abuse. They are all trained to do APS intake and they can all enter reports directly into the APS system. Then state APS supervisors at the local level review the reports and determine whether to do an investigation, which might include a home visit, interviews with the individual and others.

For reports that are screened out of the APS system – either no investigation warranted or no abuse confirmed, the person is brought back to the ADRC to explore other kinds of support and assistance they might need. As a part of their 2010 ADRC Grant, the ADRC has begun working with APS to develop criteria that identifies which APS intakes could be assisted by the ADRC with options counseling.

## Common Tools

ADRC resource coordinators and APS staff share the same IT system and can make reports directly into the APS system and can review the intake notes related to APS. If ADRC resource coordinators need additional information about an APS investigation, they can get that information from the local APS supervisors.

## Georgia

Georgia's Adult Protective Services (APS) and Aging and Disability Resource Center (ADRC) programs are administered by the same department, under the Division of Aging Services. This allows ongoing communication and collaboration between the two programs. However, none of their ADRCs are co-located with APS at the local level; they have formal partnerships with APS.

There is extensive and ongoing cross-training that occurs between ADRC and APS staff. "Gateway" staff (ADRC) at the local level are trained about how to identify possible abuse and neglect situations, trained about the APS system and process,

and they also receive supplemental training through conferences. This training helps ADRC staff know the right questions to ask to determine if an APS referral is needed. Also, APS staff regularly receive training about services offered through the ADRC and MFP programs, including Options Counseling.

**Common Tools/Processes**

The Gateway/ADRC does not use a standard screening tool to assess for the need for APS services. When an ADRC staff person identifies the potential need for APS services, they encourage the individual calling to make a report directly. APS prefers that the call come directly from the individual requesting their services. The ADRC will then follow-up within 14 days to make sure the call to APS was made. If the staff person determines that the individual is not capable of making the call themselves, the ADRC will directly call APS and make a report based on the second-hand information they have.

APS leadership made the decision to streamline the client assessment process and to align it with intake at the Gateway/ADRC level by adopting the use of the DON-R (Determination of Need – Revised). Staff in APS locations across the state are trained on its use and they use the DON-R as part of their client assessment. This allows for APS case managers and Gateway/ADRC staff to communicate more effectively when evaluating critical need for HCBS services. APS staff will enter information into the Gateway database and will refer individuals to the ADRC to request services.

ADRC, MFP, Title III program staff and APS staff use the same electronic database (AIMS) for client tracking. ADRC and MFP staff can see if in someone's case file whether APS has been involved with that individual. They are not able to view the case notes; however, they see it as a flag and know to find out more. This has proven particularly important tool for the MFP program, in helping them to ensure that they are not transitioning an individual into an abusive or potentially harmful environment.

**Evidence-Based Screening Tools for Elder Abuse, Neglect, and Exploitation**
There are many screening tools aimed to detect elder abuse, neglect, and exploitation, both by interviewing potential victims and/or perpetrators in various settings and through various methods. Many of the measures that have been studied are quite lengthy, consisting of more than 40-100 items to screen for various sub-forms of elder abuse. Some tools, like the three reviewed below, are much shorter. In addition, many states and communities have developed their own

screening tools, either from experience of caseworkers in the field, or by modifying other tools.

Because of the nature of the interaction of the Options Counselor and the individual, the most appropriate screening tools would be brief (less than 8-items) and be supported by science; that is, the tool would be psychometrically sound and could be adapted in various settings. Three evidence-based tools are identified below because of their strengths in brevity and having some level of validation: the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), Elder Abuse Suspicion Index (EASI), and the Vulnerability to Abuse Screening Scale (VASS).

***H-S/EAST***

For this tool, researchers pooled over 1,000 items from existing elder abuse assessment protocols to develop a 15 item tool which measured three aspects of abuse: (1) violation of personal rights or direct abuse, (2) characteristics of vulnerability, and (3) potentially abusive situations. Using discriminate analysis, the researchers narrowed the original 15 questions down to sic (6) to distinguish between abused and non-abused seniors.[xv]

There have been validation studies with reasonable consistency and discrete intra-observer reproducibility. Instruments have been used in African American, Hispanic, White, and Chinese populations, and translated and tested in Portuguese in South America.[xvi] Discriminant validity analyses showed that 6 items were effective in classifying elder abuse cases (71.4% - 73.9%). The false positive rate was 9.3% and the false negative rate was 35.7%. A mean score of 3 or higher indicates higher risk of abuse, a trigger for further assessment. In 2000, Moody, Voss and Lengacher assessed the psychometric properties of H-S/EAST with a sample of 100 older adults in senior housing, which offered addition support for construct validity.[xvii] In 2008, this measure was adapted in Brazil and study found similar reasonable internal consistency with discreet intra-observer reproducibility.[xviii]

The H-S/EAST tool has the following limitations. First, the measure has not been tested in patients with cognitive impairment. Second, while validity studies exist, the validity studies lack a longitudinal perspective and specific morbidity and mortality outcomes. Third, the measure does not have long term predictive validity data on morbidity and mortality.

***EASI***

EASI was aimed to be a brief tool for physician use to improve suspicion about the presence or absence of elder abuse. A literature review on elder abuse, obstacles to its identification, limitations of detection tools, and characteristics of screeners employed by physicians were used to generate elder abuse detection questions for critique by 31 doctors, nurses, and social workers in focus groups. Six resulting questions became the Elder Abuse Suspicion Index (EASI) administered by 104 family doctors to 953 cognitively intact seniors in ambulatory-care settings. Findings were compared to a recognized, detailed elder abuse Social Work Evaluation (SWE) later administered to participants by social workers blinded to the results of the EASI. The EASI had an estimated sensitivity and specificity of 0.47 and 0.75, usually took less than 2 minutes to ask, and 97.2% of doctors felt it would have some or big practice impact.

A total of 953 adults from age of 65-90 received the screening test, with completion of 85%. EASI was determined to have a sensitivity rate of 0.47 and specificity of 0.75. Content validity is considered very high, with instruments translated into French, Hebrew, Arabic, German and Spanish. Inter-rater reliability was high.[xix]

However, the EASI tool has a number of limitations. In the tool, the first items contribute to the majority of the psychometric studies available. If the first item of the EASI questions is removed, the entire measure becomes very unreliable and invalid. Despite this measure being used in multiple countries and translated into many languages, additional epidemiological studies in different populations are warranted in order to determine its performance psychometrics as an elder abuse screening measure.

***VASS***

The original 15-item H-S/EAST screening tool has been the subject of further analysis by the Australian Women's Health Survey. Two additional items were added: "Has anyone close to you called you names or put you down or made you feel bad recently?" and "Are you afraid of anyone in your family?" Then the survey group examined the reliability and validity of the resultant instrument on a nationally representative community-based sample of older Australian women (n=12,340). Their exploratory analyses led to the deletion of five of the 15 items from the H-S/EAST. The remaining 12 factors were divided into four categories which they labeled: *vulnerability, dependence, dejection, and coercion*. Further investigation revealed that "dependence" had more to do with autonomy than abuse and "dejection" with depression and mental health issues. The authors suggest that responses to the six remaining items could provide a simple screening tool for elder abuse:

1. Are you afraid of anyone in your family?
2. Has anyone close to you tried to hurt or harm you recently?
3. Has anyone close to you called you names or put you down or made you feel bad recently?
4. Does someone in your family make you stay in bed or tell you you're sick when you know you aren't?
5. Has anyone forced you to do things you didn't want to do?
6. Has anyone taken things that belong to you without your OK?

Prior studies indicate that VASS has good factor structure and construct validity. Four factors (vulnerability, dependence, dejection, and coercion) explained 51% of the variance, and these factors were internally consistent. The vulnerability and coercion factors held the strongest face and construct validity for physical and psychological abuse. The dependence and dejection factors were also valid and reliable. In addition, predictive validity was demonstrated in a 3-year period, where authors demonstrated the VASS, especially the dejection factor, was predictive of worse mental health outcomes.[xx] In addition, modified VASS has been administrated in Chinese populations, both in US and P.R. China, and demonstrated to have good reliability with Cronbach's alpha of 0.79-0.86. Moreover, content validity was examined by a group of experts, both in elder maltreatment and Chinese cultural issues. Construct validity of the measure has been tested in Chinese aging populations and has been shown to be closely correlated with loneliness, depression, and social support, further supporting the convergent validity.[xxi]

The limitations of the VASS tool are similar to those of the H-S/EAST. In the tool, the first items contribute to the majority of the psychometric studies available. If the first item of the VASS questions is removed, the entire measure becomes very unreliable and invalid. Despite this measure being used in multiple countries and translated into many languages, additional epidemiological studies in different populations are warranted in order to determine its performance psychometrics as an elder abuse screening measure.

VASS is brief, psychometrically sound, and could be adapted in various settings. Of the evidence-based screening tools available, VASS is strongest in terms of *face validity* and *content validity*, as well as provides the best translation of the construct of interest: elder abuse. A representative selection of experts has confirmed that the measure does a good job of capturing the phenomena of interest, which enhances its standing on face validity. Also, the content provides a basis for further probing as to

whether an elder has been disrespected, intimidated, coerced, or subjected to physical cruelty, and may provide leads for identifying situations of theft or subjection to undue influence. While VASS lacks key items that could stimulate concerns about the presence of self-neglect or sexual abuse, it is the most comprehensive of the tools considered in terms of capturing more of the universe of experiences that could indicate risk for abuse or exploitation.

VASS also is strongest in three other aspects of validity. Its *predictive validity* has been examined in at least two instances. This indicates that information provided by the measure is useful in predicting outcomes that theoretically and empirically should be related to the experience of abuse or exploitation. Its *construct validity* has been examined, with four major factors explaining 51% of the variance. This provides confidence that if the VASS is included in Options Counseling, it would actually measure risk for/vulnerability to abuse. The tool's degree of independent correlation with loneliness, depression, and social support indicates association but not duplication, demonstrating *convergent validity* .

**Recommendations for States Using a Screening Tool**

If a state selects to use a screening tool for elder abuse as part of their Options Counseling Program, it is recommended this be implemented during in-person interviews with the individual or caregiver as appropriate to the tool being used. While there exist differences among the methods to screen for elder abuse (telephone, computer assisted, etc.)[xxii], evidence suggests that in-person interviews may be better suited to screen for elder abuse than telephone interviews[xxiii], where participation rates tend to be lower. In addition, a recent study suggests that telephone interviews were not effective in discriminating between abused and non-abused groups.[xxiv]

Furthermore, it is recommended that practices not be implemented for Options Counselors to identify or investigate abuse. Rather, it is recommended Options Counselors be trained and implement tools or practices aimed to heighten the Counselor's suspicion for elder abuse, and subsequently ask additional questions as needed to explore the nature and context of the answers. This approach is consistent with screening methods for many other types of health conditions, psychosocial distress, and other geriatric syndromes.

Furthermore, protocols and/or tools implemented should provide the Options Counselor with information about the living environment of the individual and the relationships between the care recipient and caregiver. Such information will assist the Options Counselor in arranging for the most appropriate range of community-

based services to help maintain safety and independence. At times, such practices could also then reveal more than an elevated risk for abuse, such as a suspicion of maltreatment, in which case the Options Counselor would make a referral to the local Adult Protective Services agency.

## Attachment L: Proposed National Evaluation Framework

The following is the proposed Framework to evaluate the progress of an ADRC Options Counseling Program toward achieving its performance standards and outcomes.  This proposed framework will be finalized through a six month collaborative process between funded states, ACL, CMS and the VHA.  Once the Framework, data collection and reporting methods are finalized states can use these tools to evaluate their progress across their local ADRC sites.  ACL, CMS and VHA will use the Framework to evaluate the ADRC Options Counseling Program's progress across the states and nationwide.

**Individual Outcomes, Indicators, and Metrics:**

Individual Outcome #1:  Empowered Individuals

Indicators:  The ability of people who contact the ADRC to:

- make informed decisions about their LTSS options as a result of the information, and, if necessary, the one-on-one counseling they and/or their family caregivers receive.
- effectively and seamlessly navigate through the LTSS system and successfully access the options they have identified, from among the options that are available,  as best meeting their particular needs,  preferences and circumstances within a timeframe that meets both their immediate and on-going needs.
- have the opportunity to self-direct their services and support, and
- make optimal use of their own private resources and their informal support system,

Metrics:

- quantifiable individual-level feedback  documenting their personal experience on each of the above indicators, including measures of individual satisfaction with the process and the degree to which their needs and preferences were met, as well as an individual's confusion/frustration in trying to understand and navigate the LTSS
- number and percent of all individual s with service plans who were offered the option to self-direct and the number and percent who choose to do so.

Individual Outcome #2: Increased Community Tenure

Indicators: The ability of people who contact the ADRC to use the information and counseling they received to:

- continue to live in their own homes and communities and/or successfully return to and remain living in their own homes and communities after a stay in a nursing home, acute care setting or other facility
- maintain or improve their quality of life and self-perceived level of independence in the community

Metrics:

- quantifiable individual-level feedback regarding quality of life
- number of individuals with service plans who:
    - met eligibility criteria but avoided/delayed admission to a nursing home
    - transitioned out of nursing homes
    - avoided hospital readmission

**Systems Outcomes, Indicators and Metrics:**

System Outcome #1: Improved efficiency in the use of public resources within a state that are allocated to helping individuals learn about and access LTSS

Indicators:

- the NWD system under the ADRC Options Counseling Program serves as the single access program to LTSS within a state and used by all public programs that pay for LTSS including Medicaid, Older Americans Act, the VHA, and State Revenue Programs, to provide options counseling and streamlined access to people who either are or appear to be eligible for one or more of those programs.
- the statewide use of a Core Standardized Assessment (CSA) for all public LTSS programs and which includes an assessment of family caregivers' needs and ability to provide informal support
- Reduction in time spent by Medicaid eligibility workers in documenting and determining an individual's eligibility for Medicaid LTSS

Metrics:

- Quantifiable results from ACL, CMS and VHA monitoring, including documentation that statewide processes, procedures and tools are being used
- % of state's population residing in areas covered by a fully functional ADRC Options Counseling Program

System Outcome #2: Positive impact on state and federal LTSS and health care expenditures

Indicator:

- slower growth compared to projected growth in public LTSS and health care expenditures

Metrics:

- trends in Medicaid LTC expenditures for the geographic areas and populations served by ADRC Options Counseling Program
- rates of nursing home admissions for LTSS individuals for geographic areas and populations served by ADRC Options Counseling Program
- number of individuals with ADRC LTSS plans who were able to avoid/delay spend down and/or nursing home placement, and for how long
- trends in Medicare expenditures for post acute care individuals with LTSS needs for geographic areas and populations served by ADRC Options Counseling Program
- number of post acute care ADRC clients with service plans who avoided hospital readmissions
- % of ADRC clients with service plans who do not qualify for public programs and/or who are using their own resources, including their informal supports, to implement their service plan

**Performance Standards, Indicators and Metrics:**

Standard #1: The ADRC Options Counseling Program is a visible and trusted source of LTSS information, counseling and assistance in accessing LTSS

Indicators:

- broad public awareness, including across all income levels, ages and disabilities, of the ADRC's existence and role
- capacity to serve people of all incomes levels, including private pay individuals, older adults, people with disabilities of all ages, individuals with physical, intellectual and developmental disabilities (ID/DD), and family caregivers
- high levels of customer confidence in the ADRC Options Counseling Program's capacity to provide objective information, counseling and assistance in accessing LTSS
- the use of systematic processes, tools and up-to-date data bases by all ADRC Access Points across a state for identifying and referring to the appropriate ADRC Options Counseling Program people who could benefit from options counseling
- ADRC Access Points reflect a broad spectrum of agencies and organizations, that serve various age, disability, ethnic and income groups that are known and trusted by the populations they serve
- a statewide website on LTSS options designed for individuals that is user friendly, searchable, comprehensive and accessible to persons with disabilities

Metrics:

- quantifiable results from statewide public opinion surveys, individual-level surveys, and ACL, CMS and VHA monitoring

Standard #2: The ADRC Options Counseling Program meets the draft national standards:

Indicators:

- capacity to provide Options Counseling to individuals of all incomes levels, racial and ethnic groups, and disabilities, including at a minimum, older adults, people with disabilities of all ages, individuals with physical, intellectual and developmental disabilities, and family caregivers..
- capacity to provide immediate support to individuals in short-term crisis situations until long term support arrangements have been made

- follow-up occurs with individuals receiving Options Counseling to determine the outcomes and whether more assistance is needed
- capacity to provide individuals with assistance in planning for future LTSS needs
- Options Counseling has been incorporated into all state and local LTSS programs, care transition programs and systems integration projects
- By the end of 2013, staff who serve as Options Counselors meet the federal training and/or experience requirements and have been certified by an ACL designated entity to be an ADRC Options Counselor

Metrics:

- Quantified results of ACL, CMS and VHA monitoring and customer feedback surveys

Standard #3: ADRC Streamlined Access meets the draft national standards, and the Balancing Incentive Program requirements related to the statewide use of a standardized assessment process

Indicators:

Standardized process for helping individuals access all publicly-funded LTSS programs available in a state

- Intake and screening processes are coordinated and standardized across all ADRC partners so that individuals experience the same process wherever they enter the system.
- Standardized Assessment Instruments are being used statewide that are consistent with the Balancing Incentive Program requirements and also assess the family's needs and capacity to provide informal supports.
- Financial and functional/clinical eligibility determination processes for public programs are highly coordinated by the ADRC, so individuals experience it all as one process.
- Staff located on-site within the ADRC conduct level of care assessments that are used for determining functional/clinical eligibility, or ADRC has a formal process in place (e.g. MOUs, written protocols) for seamlessly referring individuals to the agency that conducts level of care assessments.
- ADRC staff assist individuals as needed with initial steps in completing the application (e.g., taking applications, assisting applicants in completing the

application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews).

- Staff located on-site within the ADRC can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of applicants.
- ADRC is able to track individuals' eligibility status throughout the process of eligibility determination and redetermination.
- ADRC is routinely informed of individuals who are determined ineligible for public LTC programs or services and the ADRC conducts follow-up with those individuals to provide further Options Counseling.

Metrics:

- Quantified results of ACL, CMS and VHA monitoring and customer feedback surveys
- Reduction in the average time from first contact to eligibility determination (both functional/clinical and financial) for publically funded LTSS.

<u>Standard #4: ADRC Care Transition Function help people with LTSS needs who are being discharged from an acute care or long-term care facility arrange for community services and reduce their risk of readmissions.</u>

Indicators:

- ADRC has formal agreements with local critical pathway providers, such as hospitals, physician's offices, nursing homes, rehabilitation centers, other community residential housing and service providers, and ICFs-MR that include:

    (1) An established process for identifying individuals and their caregivers who may need transition support services;

    (2) Protocols for referring individuals to the ADRC for transition support and other services; and

(3) Regular training for facility administrators and discharge planners about the ADRC and any protocols and formal processes that are in place between the ADRC and their respective organizations.

(4) ADRC options counselors serving on interdisciplinary care teams

- ADRC works with the State Medicaid Agency to serve as Local Contact Agencies to provide transition services for institutionalized individuals who indicate they wish to return to the community via the MDS 3.0 Section Q assessment.
-At least one ADRC within the state has Options Counselors trained in delivering an evidence-based care transition model

Metrics:

-Quantified results of ACL, CMS and VHA monitoring and customer feedback surveys
-Number of ADRC clients being discharged who successfully avoid readmissions

Standard #5: ADRC has a Quality Assurance Program that uses a Continuous Improvement process and a National Evaluation Framework for assessing and fine tuning its progress in achieving its Outcomes and Performance Standards.

Indicators:

- A CQI Program Manual that describes the overall organization and management of the ADRC's CQI program, along with the processes and procedures that are used to collect, analyze, and share data and information for decision-making by options counselors, program managers, administrators and policy officials to continually improve program performance.

Metrics:

- CQI Manual
- Standard and routine CQI reports
- Documentation of how CQI system and specific decisions improved performance
- Quantified results of ACL, CMS and VHA monitoring and customer feedback surveys

<u>Standard #6: Sustainability</u>

Indicator:

- The State's ADRC Options Counseling Program operations are based on a business model that documents the Program's short term and long-range financial sustainability, and includes multiple revenue sources, including revenue from Medicaid, Older Americans Act, State General Revenue, Veterans Health Administration, private payments, and other sources, based on the projected number of clients covered by the different funding sources that the ADRC expects to serve, with the revenues being sufficient to fully cover the operating expenses for a statewide program that meets can meet the outcomes and performance standards that will be established under this funding opportunity.

Metrics:

- Projected revenue and clients targets are being met.

**Major Deliverables/Performance Markers for Grantees Under this Funding Opportunity**

These grants will focus on performance, and grantee proposals that do not meet the deliverables referenced on page 28 of this announcement in their application and work plan will be required to submit corrective action plans. Failure to carry out the corrective action plan may result in suspension or termination for non-compliance. For states reporting through the Balancing Incentive Program, the report created for that program can be submitted to the ACL to satisfy their ADRC Options Counseling Program reporting requirements.

## Attachment M: Other Federal Opportunities that May Align with ADRCs

In order to reflect the joint vision of CMS, ACL, and VHA in this funding opportunity announcement, and to ensure the greatest impact and coordination between federal funding activities related to systems transformation, states are encouraged to evaluate and align their reform activities across a broad array of options. This table provides a list of some federal resources with links to additional information. States are encouraged to include alignment activities and coordination efforts in their project narrative and Work Plan.

| Federal Initiatives, Authorities, and Programs | Purpose | Link(s) to Additional Information |
|---|---|---|
| Medicaid | | www.medicaid.gov |
| Section 1115 Demonstration Project [Section 1115 of the Social Security Act (the Act)] | To test new experimental, pilot, or demonstration project approaches to providing Medicaid coverage or improving the scope and quality of benefits, or to establish innovative service delivery systems using fee for service (FFS). | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1115#waivers |
| Section 1915(c) home and community-based services waivers | Permits states to target home and community-based services (HCBS) to individuals who are at institutional levels of care statewide or in limited areas. | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html |
| Section 1915(b) waivers | Allow states to: use managed care in Medicaid, permit a county or local government to act as a choice/enrollment broker, use state savings to provide additional services, or restrict the number or type of providers of services. Section 1915(b) waiver authority may be used concurrently with other Medicaid waiver or State plan authority. | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Managed-Care-1915-b-Waivers.html |
| Section 1915(a) contract | Authorizes voluntary managed care programs statewide or in limited areas. | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html |
| Section 1932(a) State plan amendment | Permits states to implement mandatory and voluntary managed | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By- |

| | care statewide or in limited areas. | Topics/Delivery-Systems/Managed-Care/Managed-Care.html |
|---|---|---|
| SSA Section 1905(a)(13) State Plan | Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services | http://www.socialsecurity.gov/OP_Home/ssact/title19/1905.htm |
| SSA Section 1915(g)(2)(A)(ii) Targeted Case Management | Allows for targeting case management to a particular group (e.g. adults with mental illnesses). | http://www.ssa.gov/OP_Home/ssact/title19/1915.htm |
| Section 1905(t)(1) | Authorizes primary care case management services including locating, coordinating, and monitoring of health care services. | http://www.ssa.gov/OP_Home/ssact/title19/1905.htm#act-1905-t-3<br><br>http://www.ahrq.gov/qual/medicaidffs/medicaidffs1.htm |
| Section 1915(i) HCBS | States may target HCBS statewide to individuals based on need. | http://www.gpo.gov/fdsys/pkg/FR-2012-05-03/pdf/2012-10385.pdf |
| Section 1915(k) Community First Choice | Allows states to provide home and community-based attendant services that includes an additional 6 percent Federal Medical Assistance Percentage (FMAP) increase. | http://www.gpo.gov/fdsys/pkg/FR-2012-05-07/pdf/2012-10294.pdf |
| Section 1915(j) Self-Directed Personal Assistance Services | Permits states already offering HCBS or personal care services to offer beneficiary self-direction. | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Self-Directed-Personal-Assistant-Services-1915-j.html |
| Section 1937 Benchmark/Benchmark Equivalent Benefit Plans | States may offer limited Medicaid benefits based on commercial benefit plans. | http://www.gpo.gov/fdsys/pkg/FR-2010-04-30/pdf/2010-9734.pdf |
| Section 1945 Coordinated Care Through a Health Home for Individuals with Chronic Conditions | States may establish health homes to coordinate care for people with two or more chronic conditions, or with one condition at risk for another - statewide or in limited areas. | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html |
| 42 CFR Section 433.110 Mechanized Claims Processing and Information Retrieval | Allows for 90% match for the design, development and installation or enhancement of eligibility determination systems until | http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf |

| Systems | December 31, 2015. | |
|---|---|---|
| National Direct Service Workforce Resource Center | Supports efforts to recruit and retain direct service workers who help older adults and people with disabilities live independently | http://dswresourcecenter.org/tiki-index.php |
| Section 10202 Balancing Incentive Program | Offers a targeted FMAP increase of two or five percent to states whose current expenditures on LTSS comprise less than 50% of their overall spending on long-term care, and that undertake structural reforms to increase access to non-institutionally based services. | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html |
| Medicaid Incentives Program for the Prevention of Chronic Diseases | Awarded 10 grants to States to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. | http://www.innovations.cms.gov/initiatives/MIPCD/index.html |
| Bundled Payments for Care Improvement | Seeks to improve patient care by fostering improved coordination through four broadly-defined, patient-centered approaches. Three models involve a retrospective bundled payment arrangement, and one model would pay providers prospectively. | http://innovations.cms.gov/initiatives/bundled-payments/index.html |
| Money Follows the Person Rebalancing Demonstration (MFP) | Helps States rebalance their long-term care systems to transition people with Medicaid from institutions to the community. | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html |
| Community-based Care Transitions Program | Provides funding to test models for improving care transitions for high risk FFS Medicare beneficiaries by using services to manage transitions effectively. | http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html |
| State Health Information Exchange (HIE) Cooperative Agreement Program | Funds states' efforts to rapidly build capacity for exchanging health information across the health care system both within and across states. | http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__state_health_information_exchange_program/1488 |
| Health Information Exchange (HIE) Challenge Grant Program | State grants to encourage breakthrough innovations for health information exchange that can be leveraged widely to support | http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3378 |

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| | nationwide health information exchange and interoperability | |
| Health Insurance Exchange | Enables individuals and families to apply for coverage using a single application and have their eligibility determined for all insurance affordability programs through one simple process. | http://cciio.cms.gov/ |
| Initiative to reduce Avoidable Hospitalizations among Nursing Home Residents | Through this initiative, CMS will partner with eligible, independent, non-nursing facility organizations (referred to as "enhanced care & coordination providers") to implement evidence-based interventions that reduce avoidable hospitalizations. | http://innovations.cms.gov/initiatives/rahnfr/index.html |
| Medicare-Medicaid Enrollees Integrated Care Models and Financial Alignment | States will test two models (capitated and managed fee-for-service) to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health and long term services and supports for their Medicare-Medicaid enrollees | http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html |
| Million Hearts | Coordinates, and enhances cardiovascular disease prevention activities across the public and private sectors in effort to prevent 1 million heart attacks and strokes over five years. | http://millionhearts.hhs.gov/index.html |
| Multi-payer Advanced Primary Care Practices (MAPCP) | Evaluates whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas. | http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1230016.html |
| Federally Qualified Health Center Advance Primary Care Practices | Tests the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients. | http://innovations.cms.gov/initiatives/FQHCs/index.html |
| Comprehensive Primary Care Initiative Demonstration | A multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care | http://innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html |

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| | doctors who better coordinate care for their patients. | |
| Independence at Home | 16 medical practices across the country are testing the effectiveness of delivering comprehensive primary care services at home and to improve care for Medicare beneficiaries with multiple chronic conditions. | http://innovations.cms.gov/initiatives/Independence-at-Home/index.html |
| Pioneer ACO Model and Medicare Shared Savings Program | The Pioneer model is an initiative complementary to the Medicare Shared Savings Program designed for organizations with experience providing integrated care across settings. The Pioneer Model tests a rapid transition to a population-based model of care, and engages other payers in moving toward outcomes-based contracts. | http://innovations.cms.gov/initiatives/ACO/index.html |
| Community Development Block Grants (CDBG)/ HOME | Home accessibility modifications funding is made available through the consolidated planning process of local housing authorities including ramps, grab bars, etc. | http://www.hud.gov/offices/cpd/communitydevelopment/training/basicallycdbgmanual/chapter4.pdf |
| State Assistive Technology Programs | Supports state efforts to improve the provision of assistive technology to individuals with disabilities of all ages through comprehensive, statewide programs that are consumer responsive. | http://www2.ed.gov/programs/atsg/index.html |
| Centers for Independent Living (Title VII, Part C Rehabilitation Act) | The Centers for Independent Living program provides grants for consumer-controlled, community-based, cross-disability, nonresidential, private nonprofit agencies that are designed and operated within a local community by individuals with disabilities and provide an array of independent living services including information and referral, independent living skills training, peer counseling, and individual and systems advocacy. | http://www2.ed.gov/programs/cil/index.html |
| Work Incentives Planning & Assistance (WIPA) | The 102 Work Incentives Planning and Assistance (WIPA) projects across the U.S. and the U.S. territories work with SSA beneficiaries with | http://www.socialsecurity.gov/work/WIPA.html |

| | disabilities on job placement, benefits planning, and career development. | |
|---|---|---|

## Attachment N: Grant Funding Amounts for Part B

**EXISTING AGING & DISABILITY RESOURCE CENTER GRANTEES**
**FY 2012 PROGRAM EXPANSION SUPPLEMENTAL FUNDING AMOUNTS**

| State | FY 2011 Award | 90% of FY 2011 Year Award – Maximum for FY 2012 Supplement Award |
|---|---|---|
| AK | $221,953 | $199,757.70 |
| AL | $221,954 | $199,758.60 |
| AR | $203,080 | $182,772.00 |
| AZ | $221,844 | $199,659.60 |
| CA | $225,965 | $203,368.50 |
| CO | $221,663 | $199,496.70 |
| CT | $221,805 | $199,624.50 |
| DC | $226,682 | $204,013.80 |
| DE | $221,935 | $199,741.50 |
| FL | $204,340 | $183,906.00 |
| GA | $221,954 | $199,758.60 |
| GU | $216,387 | $194,748.30 |
| HI | $201,134 | $181,020.60 |
| IA | $221,954 | $199,758.60 |
| ID | $221,954 | $199,758.60 |
| IL | $230,031 | $207,027.90 |
| IN | $378,155 | $340,339.50 |
| KS | $113,394 | $102,054.60 |
| KY | $197,539 | $177,785.10 |
| MA | $221,954 | $199,758.60 |
| MD | $176,499 | $158,849.10 |
| ME | $221,954 | $199,758.60 |
| MI | $221,954 | $199,758.60 |
| MN | $221,954 | $199,758.60 |
| MT | $217,732 | $195,958.80 |
| NC | $194,848 | $175,363.20 |
| ND | $186,807 | $168,126.30 |
| NE | $215,701 | $194,130.90 |
| NH | $221,954 | $199,758.60 |
| NJ | $131,439 | $118,295.10 |
| NM | $221,954 | $199,758.60 |
| NV | $221,954 | $199,758.60 |
| NY | $204,198 | $183,778.20 |
| OH | $216,360 | $194,724.00 |
| OK | $221,939 | $199,745.10 |
| OR | $221,954 | $199,758.60 |

| | | |
|---|---|---|
| RI | $221,954 | $199,758.60 |
| SC | $215,063 | $193,556.70 |
| SD | $192,688 | $173,419.20 |
| TN | $221,080 | $198,972.00 |
| TX | $220,179 | $198,161.10 |
| UT | $221,954 | $199,758.60 |
| VA | $221,954 | $199,758.60 |
| VT | $221,954 | $199,758.60 |
| WA | $238,513 | $214,661.70 |
| WI | $219,404 | $197,463.60 |
| WV | $221,954 | $199,758.60 |
| WY | $221,954 | $199,758.60 |

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