ADRC-TAE Issue Brief: Engaging Medicaid-Related Agencies about ADRCs

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OVERVIEW

The Aging and Disability Resource Center (ADRC) initiative, funded jointly by the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS), marks a historic new partnership between aging networks and Medicaid at the federal level. At the state and local levels, ADRCs present an excellent opportunity for the aging and disability networks to partner together in collaborating with state and local Medicaid-related agencies.[1] These relationships are essential to coordinating access to all publicly-funded long-term care (LTC) programs serving older persons and people with disabilities.

Developing such partnerships can be challenging. Historically, aging networks, disability networks, and Medicaid agencies have often operated in separate "silos." In most states, and at the federal level, aging networks and disability networks have had separate relationships with Medicaid. The lack of coordination among long-term services and supports programs can make it cumbersome and time-consuming for consumers to find out about and access the appropriate services to meet their needs.

ADRCs address this problem by coordinating and streamlining access to long-term services and supports, which often requires new types and levels of collaboration that have existed in the past. This Issue Brief provides an overview of how relationships can evolve between ADRCs and Medicaid-related agencies. It discusses current integration of ADRCs and Medicaid, the role of ADRCs in streamlining access to Medicaid, examples of state and local ADRC-Medicaid partnerships, and strategies for ADRCs to engage Medicaid-related agencies.

Integration of ADRCs and Medicaid

In most ADRC grantee states, the ADRC and Medicaid agency are located in different departments (see ***Table 1***). Many of the ADRC grantees that are not in the same department as the Medicaid agency have reported challenges in partnering with Medicaid.[2] These challenges have hampered the ADRCs' ability to streamline access to Medicaid, integrate information technology systems, and implement systems for sharing data.

[1] This paper uses the term "Medicaid-related agencies," or "Medicaid function agencies," because some Medicaid program functions may not be directly administered by the Single State Medicaid Agency.

[2] The Lewin Group, *The Aging and Disability Resource Center (ADRC) Demonstration Grant Initiative: Interim Outcomes Report*, November 2006, http://www.adrc-tae.org/documents/InterimReport.pdf

Table 1: Integration of ADRC Grantees and Medicaid Agencies at State Level

Separate Agencies *23 states*	Alabama Arizona California Colorado Northern Mariana Islands Florida	Georgia Hawaii Illinois Iowa Kansas Kentucky	Louisiana Maryland Mississippi New Jersey New Mexico Ohio	Pennsylvania South Carolina Tennessee Virginia West Virginia
Same Umbrella Agency, Separate Divisions *18 states*	Alaska Arkansas Guam Idaho Indiana	Maine Massachusetts Michigan Minnesota	Montana Nevada New Hampshire North Carolina	Rhode Island Texas Vermont Wisconsin Wyoming
Same Agency and Same Division *2 states*	District of Columbia* Washington			

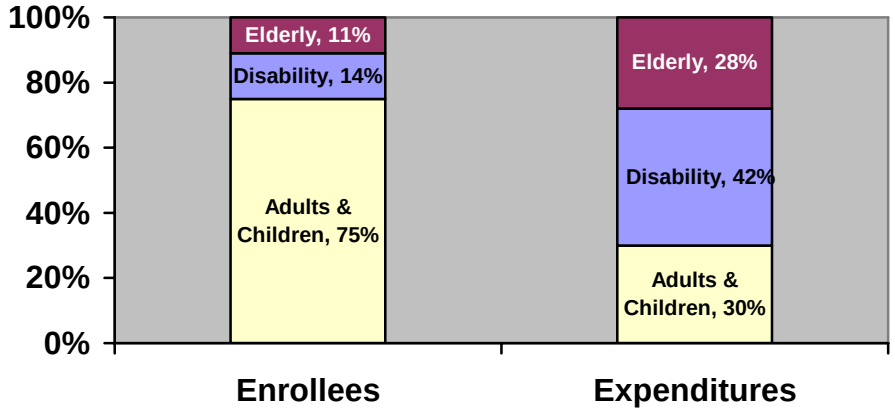
* In the District of Columbia, the Medicaid agency is the ADRC grantee.

Aging and Disability Populations in Medicaid

Although older persons and people with disabilities comprise only one-quarter of Medicaid enrollees, they account for 70 percent of Medicaid spending, due to their more intensive use of medical care and long-term services and supports (see ***Figure 1***).[3] This information may motivate Medicaid-related agencies to work with ADRCs on efforts that could reduce Medicaid expenditures related to these populations.

[3] Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance," March 2007, http://www.kff.org/medicaid/upload/7235-02.pdf

Figure 1: Medicaid Enrollees and Expenditures by Enrollment Group, 2003



Source: Kaiser Commission on Medicaid and the Uninsured, March 2007.

Stages of Medicaid/Aging/Disability Partnerships

STAGES OF PARTNERSHIPS

- The handshake
- The MOU
- The ongoing communication
- The work
- The compromises

Partnerships between ADRCs and Medicaid agencies generally involve five "stages," from an initial verbal agreement, to a formal written agreement, to the communication, work, and compromises.[4] These stages do not necessarily occur in this order, for example, communication happens throughout the entire process. Below are some recommendations for each stage.

"The handshake." In the initial "handshake" phase, representatives of the ADRC, including both aging and disability constituencies, and the Medicaid-related agency meet and agree that working together is a good concept. A proposal to work together is developed. Buy-in from the leaders of both agencies is essential to ensure that the handshake will be carried out.

"The MOU." The parties may develop a memorandum of understanding (MOU) to confirm and document the handshake agreement. The MOU describes the work to be done and the roles each partner will play. The MOU should identify, as specifically as possible, the activities to be carried out and the responsible parties.[5]

"The ongoing communication." Communication occurs throughout the entire relationship, when ADRC and Medicaid staff meet, explain what each organization does, and talk about the work that needs to be done. The ADRC should also focus on ascertaining the most pressing needs of the Medicaid-related agency and the areas under Medicaid's purview where ADRCs could assist. It will be helpful to involve an effective advocate/communicator who may be known positively by Medicaid to represent the ADRC.

[4] Dina Elani, "Streamlining Medicaid." Presentation at 2006 NCOA-ASA Conference.
[5] Examples of MOUs are available at http://www.adrc-tae.org/tiki-index.php?page=p_Agreements

Enlisting a skilled and effective neutral facilitator to be involved from the beginning can enhance the communication process. In addition, one person from each "side" could be assigned as meeting co-chairs. The co-chairs would fill the role of "taskmasters," ensuring that all points of communication are covered and all work activities and tasks have been delegated.

"The work." Face-to-face meetings between the entities should continue on a regular basis to ensure that the work set forth in the MOU is being accomplished as scheduled. These meetings also provide opportunity for talking about any unexpected outcomes or situations and any alterations that may be needed in tasks, responsible parties, or timelines. Additionally, holding regular update meetings focused on the Medicaid programs will keep the ADRC informed about Medicaid-related agency activities.

"The compromises: What's in it for me?" Medicaid-related agencies may be understaffed, with heavy demands on their time, such as implementing changes related to the Deficit Reduction Act. Hence, it is important for the ADRC to meet with the agency to identify and understand the problems it is facing and how they can work together on mutual goals. In order to form a mutually beneficial relationship with Medicaid, the ADRC may need to adjust its priorities somewhat to focus on the needs of the Medicaid agency. ADRCs may work with Medicaid in fulfilling various functions of the Medicaid program, including eligibility determination, level of care determinations, and outreach to consumers. Such partnerships could ease workloads for the Medicaid agency, while helping to streamline access to services for consumers.

At the state level, the ADRC could work with Medicaid on transitioning people out of nursing homes, implementing Money Follows the Person, working with hospital discharge planners, and providing consumers with information on Medicaid waiver programs. On the local level, the ADRC may be able to assist consumers with gathering the required documentation and completing eligibility applications. These tasks often pose major frustration for Medicaid staff, so providing such help may be particularly useful and time-saving. The section below provides additional details on the ways that ADRCs and Medicaid may work together.

THE ROLE OF ADRCs IN MEDICAID

The primary goal for ADRCs is to streamline access to long-term services and supports, and in particular Medicaid home and community-based services. ADRCs serve as single entry points for information, assistance, and access to services, making it simpler and more efficient for individuals to get the information and assistance they need. ADRC streamlining activities have helped to improve the efficiency of Medicaid programs, as well as making Medicaid more responsive to older adults and individuals with disabilities.[6] For example, ADRCs may help to reduce duplication of work and facilitate other changes in the application process to help consumers get the assistance they need in a timely manner. Achieving these goals requires a strong partnership between the ADRC and Medicaid-related agencies.

Streamlining access to Medicaid may mean that more people will obtain assistance from Medicaid to help pay for the services they need. Although this is a positive outcome for consumers, Medicaid agencies that are constrained by tight budgets may be concerned about

[6] Elani, 2006.

how increased enrollment may affect costs. However, increasing access to services that promote health, independence, and quality of life can also help prevent illness and decline in physical condition, thereby preventing the need for more costly medical and LTC services.[7]

ADRC Role in Streamlining Access to Medicaid

ADRCs have played a role in streamlining all stages of the Medicaid application process, from initial eligibility screening to final determinations.

ADRC ROLES IN STREAMLINING

- Eligibility screening
- Forms completion
- Simpler forms and online applications
- Eligibility determinations

Eligibility screening. Often, consumers are unaware of all the programs for which they may qualify, such as Food Stamps, Low Income Home Energy Assistance Program, and state funded programs. A number of ADRCs have provided screening tools and assistance to inform consumers about the programs and benefits that may be available to help meet their needs.

Forms completion. Many ADRCs also help individuals obtain the appropriate benefit application forms, accurately complete the forms in a timely manner, and collect the required documentation needed for the eligibility process for Medicaid and other public programs.

Simpler forms and online applications. ADRCs and Medicaid can work together to help streamline access by simplifying application forms. This could include shortening the forms, reducing the number of forms, improving the layout of the forms to make them more user-friendly, or making them more accessible. Several ADRC grantees have collaborated with Medicaid to provide applications that can be submitted online or application forms that can be downloaded and printed from the Internet and submitted by mail, fax, or in person.[8]

Medicaid financial and functional eligibility determinations. Federal regulations stipulate that the state Medicaid agency may delegate final Medicaid eligibility determination only to the local agency administering the Medicaid State Plan.[9] If ADRC staff are part of the same department as the Medicaid agency and the state has designated the department as the "single state Medicaid agency," as many have done, the department may be more easily able to establish procedures to meet federal requirements and allow the ADRC to make eligibility determinations. If they are not part of the same agency, Medicaid agency staff must approve the ADRC's eligibility determinations. Another approach, used in some states, is to have Medicaid eligibility staff co-located in the ADRC or linked electronically.

Federal regulations state that non-Medicaid agency employees may perform only "initial processing" functions, such as taking applications, assisting individuals in completing applications, obtaining required documentation to complete the application, and conducting any necessary interviews. Thus, if the Medicaid agency wanted to delegate Medicaid eligibility

[7] The Lewin Group, "Issue Brief on Prevention: Considering Prevention in the Development of an Aging and Disability Resource Center," November 2004, http://www.adrc-tae.org/tiki-download_file.php?fileId=1669

[8] The Lewin Group, "Online Medicaid Screening and Applications," June 2007 http://www.adrc-tae.org/tiki-download_file.php?fileId=26546

[9] 42 CFR 431.10. See also ADRC Fall 2005 National Meeting, "Determining Medicaid Eligibility," http://www.adrc-tae.org/tiki-download_file.php?fileId=2091

determination to persons other than a single state Medicaid agency state employee, it would probably require a waiver to do so.

Coordination with Other Streamlining Activities

ADRCs have also coordinated with Medicaid and other agencies on other systems change efforts in the states.

Nursing facility diversion and transition. ADRCs can play an important role in state efforts to divert people from institutional care[10] and transition nursing home residents back into the community.

For example, in **Wisconsin**, state law requires that nursing facilities report each new admission to the ADRC when a new resident's LTC needs are projected to last at least 90 days.[11] ADRC staff then contact the resident to offer options counseling to discuss potential community alternatives.

In **Indiana**, some options counselors are assigned to certain nursing homes and visit regularly and coordinate with social workers there to identify individuals interested in transition.[12] The ADRC contacts individuals who enter nursing homes if there is a possibility that they might return to community living. A non-profit nursing home trade association is represented on the Indiana ADRC Advisory Board and shares information that can assist ADRC efforts to promote transition options. ADRC pilots have trained nursing home staff regarding transition possibilities.

Money Follows the Person. ADRCs have also coordinated with Medicaid agencies and other organizations in applying for Money Follows the Person Rebalancing Demonstration (MFP) grants. In Spring 2007, 20 ADRCs reported coordinating with MFP. For example, **Georgia**'s MFP demonstration includes ADRCs as important partners in implementing the demonstration. Enacted by the Deficit Reduction Act of 2005, MFP grants assist states in changing their LTC systems to reduce reliance on institutional care and give consumers more choices.

REIMBURSEMENT FOR MEDICAID ACTIVITIES

Medicaid is jointly funded by the federal government and the states, with the federal government providing matching funds to states. The federal matching percentage for the cost of services covered by Medicaid varies by state, from 50 percent to 76 percent, depending on state per capita income.[13] States with lower average personal incomes receive a higher federal match.

The federal government will also match expenditures to support the "efficient and effective" administration of the Medicaid program. This administrative federal financial participation (FFP) is typically 50 percent of the costs, but in certain cases, enhanced match of up to 90 percent is available. ADRC Medicaid administrative activities may be eligible for

[10] The Lewin Group, "ADRC Roles in Rebalancing Long Term Care Systems: Diversion Initiatives," July 2005, http://www.adrc-tae.org/tiki-download_file.php?fileId=2804&PHPSESSID=72e0bbdd1e1c945a7536e6044e6dc2cf

[11] Ibid.

[12] State examples are from the SARTs provided by ADRC grantees to The Lewin Group, Lewin's Fall 2006 SART Streamlining Access analysis, and conversations with state ADRC grantee contacts.

[13] Kaiser Commission on Medicaid and the Uninsured, March 2007.

administrative FFP. For additional information, see "How to Secure Medicaid Federal Financial Participation (FFP) for ADRC Functions: *The Basics*."[14]

Another resource is the Financial Plan section of the ADRC Business Plan Template,[15] which describes ways to secure revenues to fund the operation of the ADRC. This section describes how to create a business case to justify the investment of state funds, secure the maximum amount of federal financial participation (FFP), and obtain additional funding from other sources.

ADRC EXAMPLES

Partnerships between ADRCs or agencies performing ADRC-related activities and Medicaid-related agencies work in a variety of ways, including information sharing, MOUs, and co-location of staff.[16] Below are some examples of the ways in which ADRCs have partnered with Medicaid-related agencies.

Memorandum of Understanding (MOU)

In many states, the ADRC, the Medicaid agency, and other state agencies have developed a memorandum of understanding (MOU) to confirm the relationship between the parties.

In **Arizona**, MOUs were signed between the core partners of the Maricopa and Mohave ADRCs, including the Department of Economic Security, Division of Aging & Adult Services (DES/DAAS), the Arizona Health Care Cost Containment System (the single state Medicaid agency), AAAs, and Independent Living Centers. In the agreements, all agencies agree to partner to meet the goals of the ADRC.

In **South Carolina** (where the ADRC and Medicaid are in separate agencies), staff from Medicaid eligibility and the HCBS waiver programs serve on the management team for the project. They have been critical to the development and implementation of the Medicaid Long Term Care online application, (called "Medicaid e-form" in South Carolina), the Gap Assistance Pharmacy Program for Seniors (GAPS) online application, the electronic referral process, and coordination between offices at the local level. A MOU has been established with the State Unit on Aging (ADRC grantee) on behalf of the ADRCs and the Medicaid agency to share data, make electronic referrals, and conduct preliminary screenings for long-term care Medicaid. One ADRC (Appalachia) cost-shares a Medicaid eligibility worker. Staff from the Community Long Term Care offices are trained in use of the referral database, client intake system, electronic referrals, and eforms. A MOU has also been established with the state Department of Vocational Rehabilitation, the primary agency that works with individuals with disabilities toward employment, so that the local offices can share client data with the ADRC.

In **New Jersey** (where the ADRC and Medicaid are in separate agencies), the MOU states that the Medicaid agency is a part of the State Management Team for the ADRC initiative.

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[14] The Lewin Group, "How to Secure Medicaid Federal Financial Participation (FFP) for ADRC Functions: *The Basics*," May 30, 2007, http://www.adrc-tae.org/tiki-download_file.php?fileId=26609

[15] The Lewin Group, "ADRC Business Plan Template," April 2005, http://www.adrc-tae.org/tiki-download_file.php?fileId=2845

[16] The Lewin Group, November 2006.

Significant contributions have been made to the ADRC by Medicaid's ongoing participation in the ADRC State Management Team. The state is committed to statewide expansion of the ADRC model. The ADRC has collaborated with the state Medicaid agency to streamline eligibility determination for home and community-based services through a "fast track" process, global budgeting, and to pilot a Hospital At Risk Criteria/Pre-Admission Screening (ARC-PAS) process. The benefit of this pilot effort is the integration of Area Agencies on Aging (AAAs) into the current PAS process. This will strengthen the working relationship and the processes between the Hospital Discharge Planners and the AAAs. As a result, it will increase the discharge options for individuals (Medicaid/Non-Medicaid eligibles) wishing to return to the community with home and community based services.

The **Montana** ADRC agency entered into a MOU with the Medicaid agency that establishes their partnership for meeting the goals of the ADRC grant. The agreement covers potentially developing and implementing an electronic application for publicly funded services, educating the public, developing and implementing an FFP proposal to receive Medicaid administrative funds for some ADRC functions, and Medicaid participation in an ADRC advisory council.

The **Louisiana** ADRC signed a MOU with the state Medicaid agency to share data and enable them to more effectively identify seniors in need of services, avoid duplication of services, and coordinate limited resources.

In October 2007, the **Iowa** Department of Elder Affairs, the ADRC grantee, signed an MOU with the Department of Human Services, the State Medicaid Agency establishing how the two agencies would work together to meet the goals of the ADRC program.

Table 2 provides additional examples of such MOUs and some of the topics covered.[17]

[17] Examples of MOUs are available at http://www.adrc-tae.org/tiki-index.php?page=p_Agreements .

Table 2: Examples of Topics Addressed in ADRC/Medicaid MOUs

State	ADRC-related advisory committee/ work group	Developing proposal for FFP	Streamlining access / systems change	Developing electronic application	Screening/ intake/ application/ eligibility determination	LTC consumer education	Communication, meetings, & information sharing	Staff training	Co-location of staff
Arizona			X			X		X	
Arkansas			X		X			X	
Florida	X				X		X	X	X
Indiana	X								
Maryland			X				X		
Maryland (Howard County)	X				X				
Montana	X	X	X	X		X		X	
New Jersey	X	X	X		X	X	X	X	X
Iowa	X		X		X	X	X		
Rhode Island	X		X				X		
South Carolina			X	X	X		X	X	X
Wisconsin (Richland County)					X		X		

An area where MOUs may be particularly useful is in specifying a process for data sharing and protecting customer confidentiality, for example Medicaid sharing data on individuals' eligibility status. ***Table 3*** provides examples of data sharing agreements in MOUs between ADRCs and Medicaid.

Table 3: Examples of Data sharing agreements in ADRC/Medicaid MOUs

State	Data sharing agreement in MOU
Florida	The parties agree that, if they determined that the MOU requires the sharing of personal health information, they will execute the necessary Business Associate Agreements as required by HIPAA.
Maryland (Howard County)	The ADRC agency will use an Internet-based database for tracking client intake, needs assessment, care plans, utilization, and costs. The ADRC may provide staff and terminals/kiosks in the Medicaid office to assist customer and/or staff access to the database. Confidential client information will be protected and unavailable to non-employees.
Rhode Island	The parties agree, "subject to applicable legal requirements and relevant confidentiality standards, to share relevant information about each Department's programs, as needed, in order to coordinate work and efforts of the ADRC."
South Carolina	If an individual is found ineligible or put on the waiting list for Long Term Care services, Community Long Term Care (with the client's permission) will contact the ADRC to see if they can offer any services.
Wisconsin (Richland County)	If an individual referred by the ADRC is found ineligible for services, Medicaid will within one working day notify the ADRC regarding the negative outcome of financial eligibility determination. If eligible, Medicaid will notify the ADRC of eligibility status either the same day or not later than 10:00 am the next working day.

Co-location

In several states, Medicaid eligibility staff are co-located at the ADRC, either on a full-time basis or part-time for a certain number of days a week. For example:

In **New Hampshire** (where the ADRC and Medicaid are in the same umbrella agency), the statewide New Hampshire ServiceLink Resource Center (ADRC) is contracted as a business associate with the state, and sharing of information is fluid between the New Hampshire Department of Health and Human Services and the ADRC. Long-term care nurses are co-located at all 13 ADRC sites. These nurses perform functional assessments for eligibility for Medicaid-funded nursing home and home- and community-based care waiver programs. Staff from the Division of Family Assistance (DFA), which administers Medicaid, are also co-located at all 13 ADRC sites. They are on-site for a minimum of one day a week and take three to four appointments that day, assessing eligibility for nursing facility and home- and community-based care waiver programs, Food Stamps, Medicaid for Employed Adults with Disabilities (MEAD), Medicaid, and QMB/SLMB. At three ADRC locations, ADRC staff are acting as pilot sites to process electronic applications for QMB/SLMB eligibility for the Division of Family Assistance. In addition to co-locating staff at the local level, these staff are actively part of the ADRC team, participating in local team meetings, trainings, and client coordination. At the state level, representatives from DFA are taking part in the management team activities, including data sharing, reporting, staff development, and communication and compromises. A

document was developed that provides an overview of the roles and responsibilities of the ADRC and DFA.

In **Maryland** (where the ADRC and Medicaid are in separate agencies), collaboration and co-location of health, social services, and aging staff, through formal agreements, continue to be key to streamlining eligibility determination and application processes in both ADRC pilot sites. In Howard County, the ADRC (Maryland Access Point (MAP)) is co-located with the local health department's Adult Evaluation & Review Services staff and has an MOU with the local social services agency that will result in the eligibility staff being available to handle Medicaid applications at the MAP site on scheduled days. An MOU was signed by three partner agencies and is revised every two to three years as needed.

Rhode Island's ADRC, THE POINT (which is in the same umbrella agency as Medicaid), has streamlined consumer access to programs and services by partnering with the state Medicaid agency. In July 2006, an MOU[18] was signed between the Department of Elderly Affairs, the ADRC grantee, and the Department of Human Services, which administers the Medicaid program in the state. In the MOU, the two departments agree to cooperate in implementing the ADRC and to work toward streamlining access to LTC services in the state. The ADRC reports that the Medicaid agency has hired two additional Medicaid Benefits Specialists to be co-located at THE POINT and has also given ADRC staff access to the Medicaid eligibility screen. This provides consumers with seamless information, eligibility screening, and assessment.

In **Idaho** (where the Medicaid agency and the ADRC are within the same umbrella agency), the ADRC has three permanent full-time Medicaid staff persons dedicated to ADRC work, plus a standing line item in the budget for one contracted staff person through the AAA for the ADRC.

In **South Carolina** (where the ADRC and Medicaid are in separate agencies), the ADRC has a Medicaid Eligibility Specialist co-located at the Appalachia ADRC. The cost of this worker is shared between the ADRC and the Medicaid agency. This provides consumers with seamless information, eligibility screening, assessment, and eligibility determination. If this arrangement is successful, Medicaid eligibility workers may be cost-shared and co-located within all ADRCs in the state in the future.

Overcoming barriers to working with Medicaid

In some states, ADRCs have had substantial barriers to overcome on the road to partnering with Medicaid-related agencies.

For example, in **West Virginia** (where the ADRC and Medicaid are in separate agencies), it was a grant goal to implement a process where all individuals in the pilot areas who had applied for nursing home care or the Aged & Disabled Waiver program would be contacted by their local ADRC to make sure they had information on all LTC services and were making informed choices. Accomplishing this goal was a significant challenge.

[18] The MOU is available on the ADRC-TAE website at http://www.adrc-tae.org/tiki-download_file.php?fileId=2798

The primary challenge involved privacy rules and whether the ADRCs could receive the information about who had applied for nursing home care or waiver services. State Medicaid lawyers made the decision that they could not. Eventually, the goal was achieved, by adding another step in the process. Instead of going directly to the ADRC, contact information on all individuals who applied for nursing home care or Aged & Disabled Waiver services now goes to the state Bureau of Senior Services. The Bureau contacts each consumer by mail to get written permission for the local ADRC to contact them. Once permission is given, the ADRC contacts the individual to discuss LTC service options.

STRATEGIES FOR ENGAGING YOUR STATE MEDICAID-RELATED AGENCY

The ADRC will need a list of Medicaid agency staff, such as an organizational chart, if available. Be sure to select the right person for the initial contact. It is also important to start at a high level dialogue (e.g., ask the State Unit on Aging director to reach out to the state Medicaid director).

Following are some strategies for engaging Medicaid-related agencies: [19]

Explain why the ADRC should be a priority. Medicaid agencies are likely to be understaffed, with a lot of demands on their time. Thus, the challenge for ADRCs is to convince the Medicaid agency to make coordinating with them a priority. The key message is "what the ADRC can do for the Medicaid agency." It can help to point to the successes of ADRCs in efforts that may save Medicaid money.

Be clear what goals ADRCs have for improvement. Do you want to make the process easier for an individual applying to Medicaid? Do you want to shorten the eligibility timeline? Do you want to make sure people are served in their own homes?

Do your homework. The ADRC must understand the goals and priorities of the Medicaid agency. Study your state's Medicaid eligibility flowchart. Have Medicaid eligibility experts on staff. Become an expert on how the process works. Understand what practices are required by CMS, what's become standard practice, and what's required by your state.

Join existing quality improvement efforts in your state Medicaid agency. Identify current Medicaid agency efforts and focus areas and try to offer as much assistance as possible.

ADDITIONAL RESOURCES

Below are a number of additional resources that may be helpful in partnering with Medicaid-related agencies.

Background on Medicaid:

Kaiser Commission on Medicaid and the Uninsured, The Medicaid Program at a Glance, March 2007, *http://www.kff.org/medicaid/upload/7235-02.pdf*

[19] Roger Auerbach, "Coordinating with State and Local Medicaid Offices to Streamline Access," ADRC Spring 2005 National Meeting, February 27, 2005, http://www.adrc-tae.org/tiki-download_file.php?fileId=1392 ; The Lewin Group, "Strategies for Building Collaboration," September 22, 2004, http://www.adrc-tae.org/tiki-download_file.php?fileId=1678.

Contact information for State Medicaid Directors:

National Association of State Medical Directors, State Medicaid Websites (includes links to state Medicaid agencies' websites), *http://www.nasmd.org/links.htm*

Medicaid Funding:

The Lewin Group, How to Secure Medicaid Federal Financial Participation (FFP) for ADRC Functions, May 30, 2007, *http://www.adrc-tae.org/tiki-download_file.php?fileId=26609*

National Association of State Directors of Developmental Disabilities Services (NASDDS), Claiming Federal Reimbursement for Management Information System Improvements, August 25, 2003, *http://www.hcbs.org/files/3/125/PA_01_2003.pdf*

Office of Disability and Aging, Medical Assistance Administration, District of Columbia, Enhanced Match Advance Planning Document for Case Management MIS, undated, *http://www.nashp.org/Files/DC_Case_Management_Software_Description.doc*

ADRC Business Planning:

The Lewin Group, ADRC Business Plan Template, April 2005, *http://www.adrc-tae.org/tiki-download_file.php?fileId=2845*

The Lewin Group, Business Planning Tools for Aging and Disability Resource Centers, May 2004, *http://www.adrc-tae.org/tiki-page.php?pageName=TAE+Issue+Brief%3A+Business+Planning+Tool*

Building Collaboration with Medicaid-Related Agencies:

The Lewin Group, Strategies for Building Collaboration, September 22, 2004, *http://www.adrc-tae.org/tiki-download_file.php?fileId=1678*

The Lewin Group, "The Medicare Modernization Act and ADRCs," July 2005, *http://www.adrc-tae.org/tiki-download_file.php?fileId=1807*

ADRC Medicaid-Related Activities:

The Lewin Group, Issue Brief on Prevention: Considering Prevention in the Development of an Aging and Disability Resource Center, *http://www.adrc-tae.org/tiki-download_file.php?fileId=2810*

The Lewin Group, The Aging and Disability Resource Center (ADRC) Demonstration Grant Initiative: Interim Outcomes Report, November 2006. *http://www.hcbs.org/moreInfo.php/topic/218/ofs/30/doc/1416/Level_of_Memorandum_of_Understanding_and_Agreement*

The Lewin Group, ADRC Roles in Rebalancing Long Term Care Systems: Diversion Initiatives, July 13, 2005, *http://www.adrc-tae.org/tiki-download_file.php?fileId=2804&PHPSESSID=72e0bbdd1e1c945a7536e6044e6dc2cf*