PAYER/PROVIDER CONSULTING

STATE PROMOTION OF ADULT PROTECTIVE SERVICE PROGRAM EFFICIENCIES

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As more states pursue reorganization of their health and human service programs, there is a tremendous opportunity to promote greater efficiencies and address a critical and expensive problem facing states – the increasing healthcare expenditures associated with vulnerable adults or those who are abused, neglected, or exploited (ANE). The recommendations proposed in this issue brief take into account the current state budget landscape, opportunities for additional funding, and best practices currently implemented in several states.

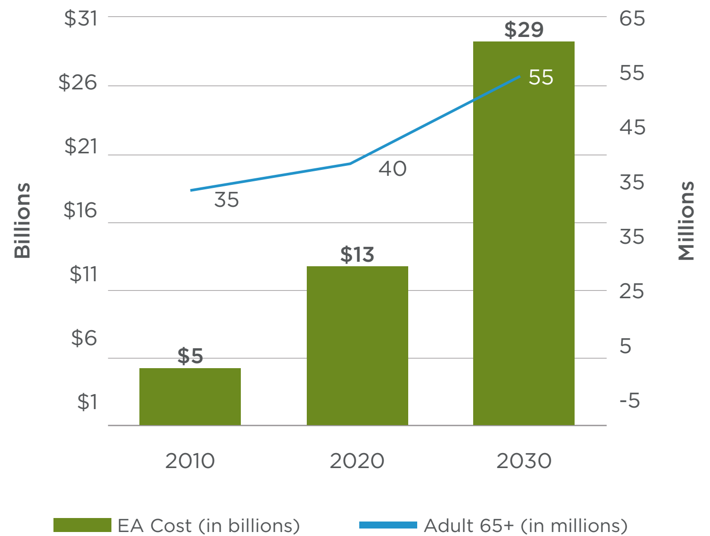
The growing number of ANE adults, particularly those who are disabled or elderly, has enormously negative health, social, and financial implications for states. In 2015, more than 4.4 million older Americans were victims of ANE,[1] and more than 70 percent of people with disabilities reported that they had been victims of abuse.[2] More than half of all victims of abuse are placed in long-term care facilities for the remainder of their lives, costing states millions of dollars in institutional care reimbursement. A study published in the *Journal of Public Health* found that the annual healthcare cost associated with elder abuse was $5.3 billion.[3] Based on current population projections, healthcare costs could, conservatively, exceed $25 billion a year by 2030.[4]

ANE crimes have a profound impact on victim health and welfare, including:

- A 300 percent higher risk of death within one year[5,6]
- Increased bone and joint problems
- Digestive problems
- Depression and/or anxiety
- Higher incidence of chronic pain
- More cases of high blood pressure and heart problems than adults who do not experience ANE[7]

HOW DO STATES WITH BUDGET AND STAFFING CONSTRAINTS CURRENTLY ADDRESS THE GROWING ELDER ABUSE AND NEGLECT CRISIS?

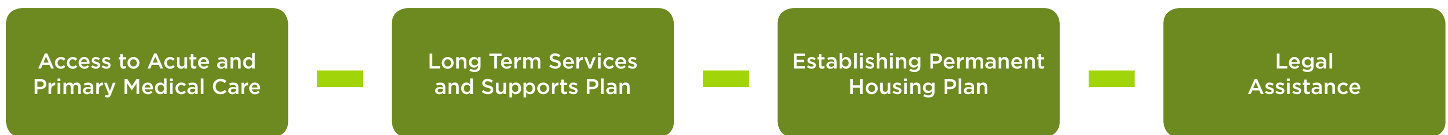
There is limited Federal funding and oversight designated to Adult Protective Services (APS). So while states have passed numerous laws and regulations to address this growing problem and are leveraging a variety of funding streams to assemble an APS safety net, vast disparities still exist in state and local program quality as well as inter-agency coordination. States have increasingly scarce resources, and as the at-risk population grows, it poses significant social and financial risk for those states that fail to respond to the crisis. Medicaid programs have become the safety-net for many victims of abuse. Elder abuse victims are four times more likely to be admitted to a nursing home, victims of abuse use healthcare services at a higher rate, and almost one in 10 financial abuse victims will turn to Medicaid as a direct result of their victimization.[8,9]



To mitigate the strain on state and local budgets, states have turned to several funding streams to address the ANE crisis, including:

- State funding
- Social Service Block Grants
- Older Americans Act funding
- Elder Justice Act funding
- Medicaid programs
- U.S. Department of Justice[10]

A standard APS program encompasses a number of intervention elements that typically include:



The expense to states specific to providing these services occurs on both the front and back ends of an abuse investigation:

1. **Front-end expenses to the state.** There is a lack of federal funding for APS, thus the majority of APS programs across the United States are primarily state-funded. Despite the lack of funding, states providing Medicaid waiver services must respond to alleged instances of ANE of participants, have a process for evaluating reports, conduct investigations, and ensure there are appropriate safeguards to protect the population and prevent ANE.[11]

2. **Back-end expenses to the state.** APS interventions currently rely heavily on institutional care, which is paid mostly by state agencies through Medicaid or other state-funded services. As the at-risk population continues to grow, states are forced to invest additional funds in staffing, housing, and service delivery for victims of ANE. The lack of resources and inter-agency coordination limit state prevention activities. As stated previously, almost one in 10 financial abuse victims will turn to Medicaid as a direct result of their victimization. [12]

HOW CAN A STATE STRENGTHEN AND EXPAND SAFETY NET RESPONSES TO VULNERABLE ADULTS, INCLUDING ADULTS WITH INTELLECTUAL AND PHYSICAL DISABILITIES?

To strengthen existing systems, states must ensure that adequate staffing and resources are available to protective service programs. In addition, for program success, agencies such as those shown in the graphic to the left must be aligned to create a coordinated assessment and service delivery network focused on preventing ANE, reducing recidivism, and establishing interventions that rely less on institutional placement.

A collaborative network of various state agencies requires a common information or data-sharing system that allows multiple agencies with different governing entities and funding streams to share information about adults identified as victims. Information-sharing capabilities allow for the creation of comprehensive coordinated care plans that include medical, behavioral, social and housing solutions.

State Example: Minnesota Adult Protective Services Unit

- The Department of Human Services Adult Protective Services Unit provides training and consultation to citizens, service providers, counties, law enforcement, and state agencies regarding the Minnesota Vulnerable Adult Act, the State law establishing the unit.
- State law mandates reports by social services, law enforcement, legal/criminal justice, aging services providers, disability services providers, government employees, and healthcare professionals.
- The Minnesota Adult Abuse Reporting Center operates 24 hours a day, seven days a week for the public and mandated reporters. Web-based reporting is also available.
- The State provides training, guidelines to the investigation, and structured decision-making tools in adult protection.
- The program relies on State, SSBG, OAA, and Medicaid funding streams.
- The program serves individuals 18+ years of age. There are approximately 29,000 cases reported per year.

Source: *http://www.napsa-now.org/wp-content/uploads/2012/06/BaselineSurveyFinal.pdf and http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_005710*

Specific strategies to promote multi-agency coordination for vulnerable adults, including homeless populations, may consist of:

- Coordination of multiple funding sources (SSBG, CSBG, OAA, Medicaid)
- Developing an information system solution for inter-agency care coordination and related communication, which, if provided by the Medicaid agency, may be eligible for a 90 percent match of federal funds
- Identification of a lead agency responsible for end-to-end assessment and care coordination
- Contracting with state Medicaid agencies to allow for up to a 50 percent FMAP cost share for the cost of service coordination provided to Medicaid beneficiaries by APS case management
- Establishing formal inter-agency agreements that establish roles and responsibilities, as well as standardized communications protocol (data systems, forms, hierarchy, etc.)
- Formalizing the role of primary, acute and sub-acute, and behavioral health providers throughout end-to-end APS reporting, investigation, and intervention activities

States can meet these growing demands through funding and programmatic realignment. Formal inter-agency agreements may allow for increased federal funding without the need for additional state funds for APS programs. Inter-agency case management and care coordination can promote less costly community-based interventions that allow adult victims of ANE to remain in the community, thereby reducing the use of institutionally based long-term care placement – all of which ultimately will lead to better outcomes, at reduced costs.

ENDNOTES

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