Adult Protective Services and Medicaid: Intersections in Policy, Practice, and Federal Funding

Findings from the ADvancing States National Survey of Adult Protective Services

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Executive Summary

Adult Protective Services (APS) are social services provided by state and local governments and other nonprofits to older persons and/or adults with disabilities who are at risk of being abused, neglected, sexually assaulted, or financially exploited, or are experiencing self-neglect. The types of maltreatment investigated vary from state to state. APS definitions, standards of practice, and eligibility requirements vary from jurisdiction to jurisdiction. In most states, APS serve populations 18 and older, while a few programs only serve older persons aged 60 and above. In many states, APS clients are referred to as "vulnerable adults". This includes adults 18 and older with a significant risk of harm because of a physical and/or mental disability.

Medicaid offers health coverage to millions of Americans, including eligible older adults and individuals with disabilities.[1] It is managed by individual states in compliance with federal regulations and is financed through state governments and the federal government. APS and Medicaid often share common clients and Medicaid is a critical program for many APS clients. APS programs provide assistance with Medicaid, such as with referring clients to Medicaid or assisting clients with Medicaid applications. Additionally, Medicaid administrative claiming (MAC) can help with APS staffing, and Medicaid services can support APS clients. The purpose of this issue brief is to explore the relationship between Medicaid and APS.

[1] Medicaid.gov Keeping America Healthy. Medicaid. Retrieved February 28, 2025. https://www.medicaid.gov/medicaid/index.html

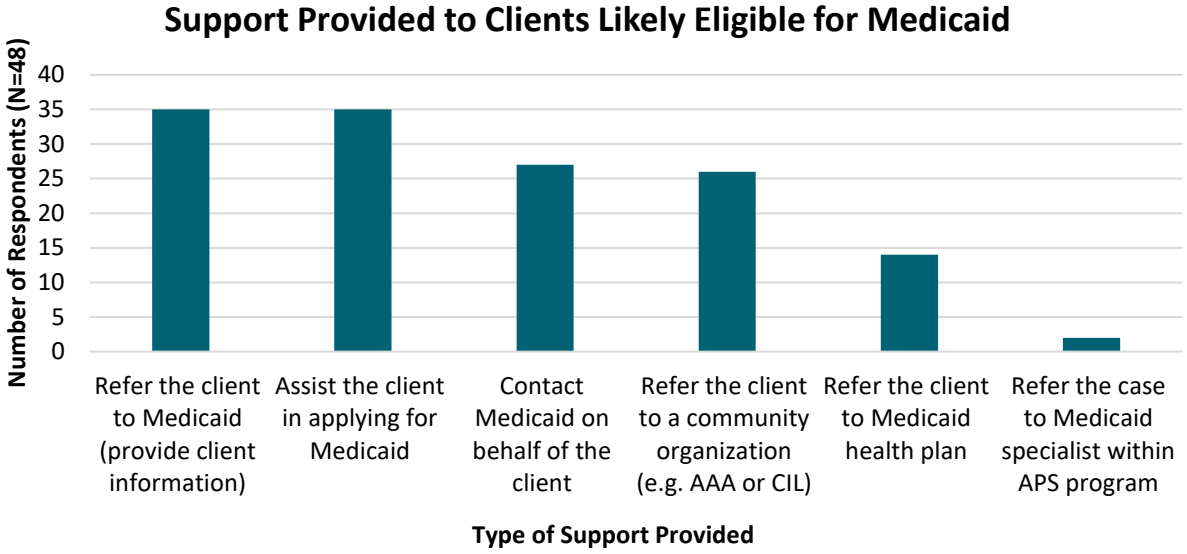
Background and Methodology

The 2022 National Survey of APS Programs was designed to assess the current landscape of APS. ADvancing States surveyed state APS programs using a web-based survey instrument. The survey was disseminated to ADvancing States' state members, who were requested to forward it to the person responsible for APS in their state.[2] Depending on how the program is administered, some county APS programs provided assistance with the state agency response. The survey was in the field in March 2022, with follow-up to ensure responses from all 50 states and the District of Columbia. This brief includes data from a total of 51 APS programs. Medicaid financing can be used to support APS, and there are opportunities to support and increase relationships with Medicaid. The 2022 survey specifically asked questions to examine the connection between APS and Medicaid.

What type of support does APS provide to clients likely eligible for Medicaid?

While only two state APS programs reported that they employ Medicaid eligibility assistance specialists, many states indicated that they assist APS clients likely eligible for Medicaid in various capacities. For instance, 35 states reported that they refer the client to Medicaid; 35 states also assist the client in applying for Medicaid; 27 states contact Medicaid on behalf of the client; 26 states refer the client to a community organization (e.g., Area Agency on Aging (AAA) or Center for Independent Living (CIL)); 14 states refer the client to a Medicaid health plan; and two states refer the client to a Medicaid specialist within the APS program (figure 1).

Figure 1



Description: Figure 1 is a bar chart of the types of support that APS programs provide to clients likely eligible for Medicaid. There was a total of 48 state respondents. An analysis of data is in the text.

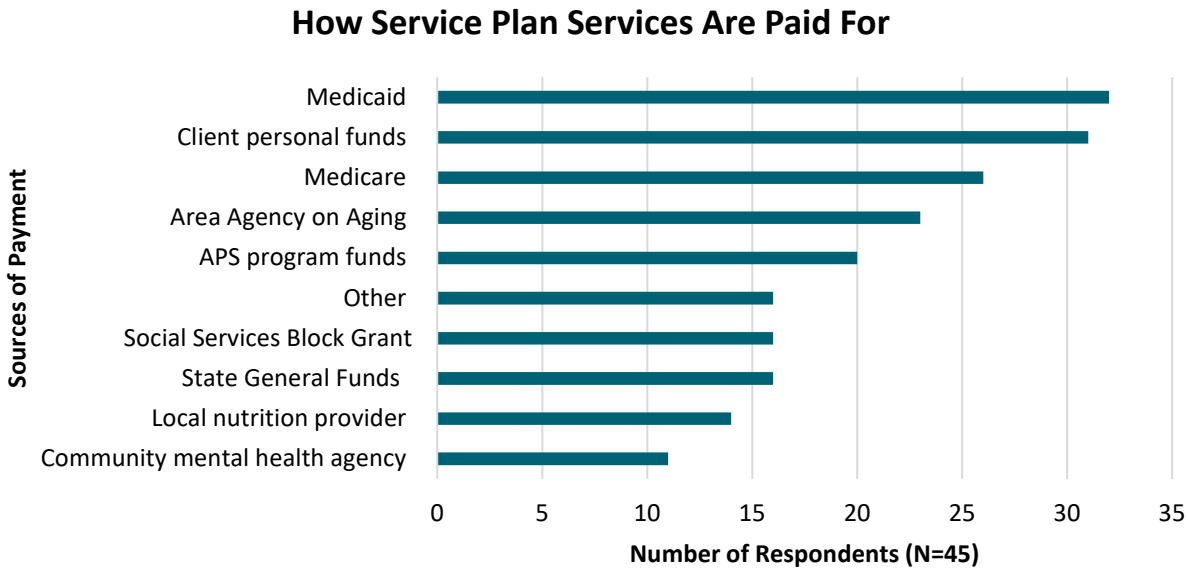
[2] ADvancing States' members oversee the implementation of the Older Americans Act, and many also function as the operating agency in their state for Medicaid waivers that serve older adults and individuals with disabilities. Approximately one-half of ADvancing States members are responsible for administering Adult Protective Services.

How can Medicaid financing support APS?

Client Services Support

Medicaid financing can support APS clients in a couple of ways. Medicaid may be a source of funding for services needed by APS clients who are Medicaid recipients. Medicaid was reported as the top source for how service plan services are paid for, with 32 states reporting Medicaid as a funding source for service plan services (figure 2). Additionally, funds from MAC can be used to support case management for APS clients.

Figure 2



Description: Figure 2 is a bar chart representing how service plan services for APS clients are paid for. There was a total of 45 state respondents. Medicaid was the top response, with 32 states, followed by client personal funds (31 states) and Medicare (26 states). Twenty-three states reported Area Agencies on Aging and 20 states reported APS program funds. Less than 20 respondents reported other (16 states), Social Services Block Grant (16 states), State General Funds (16 states), local nutrition provider (14 states), and community mental health agency (11 states).

APS Program Support

In addition to client services support, Medicaid financing can also support APS programs. The APS program may be eligible to receive Medicaid administrative funding to offset the time it takes for APS staff to help Medicaid clients. Medicaid administrative dollars can be used to pay for certain expenditures and activities performed by state agencies in support of Medicaid beneficiaries. The process of tapping into Medicaid administrative dollars is known by two names: **Medicaid administrative match** and **Medicaid administrative claiming (MAC)**. Medicaid related expenses may be eligible for federal reimbursement at the 50 percent federal match rate for regular administrative activities, and 75 percent federal match for what is considered enhanced match.[3] As will soon be discussed, there are also federal match rates up to 90 percent available for Medicaid systems funding.

[3] National Archives Code of Federal Regulations. § 433.15 Rates of FFP for administration. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-A/section-433.15

Funds from MAC can be used to directly support APS programs, such as covering staffing costs. At the time of the 2022 survey, 13 out of 49 states reported that their program utilizes Medicaid administrative match.

In order for an APS program to access Medicaid administrative funds, specific steps must be taken. **Appendix A** provides a more detailed description of these steps. In short, the APS program must seek the support of its parent agency and work directly with the state Medicaid agency.[4] The Medicaid program and APS will need to identify a source of funds for the state match for the Medicaid administrative dollars directed to APS. The Medicaid and APS agencies must identify the types of APS activities that may be eligible for Medicaid administrative funds. The most likely APS activities related to Medicaid-eligible clients include intake and screening, follow-up investigation, service planning, and training APS staff about Medicaid, including eligibility. Additionally, many APS programs employ nurses, who are often involved in complex cases. When nurses are working with Medicaid-eligible clients, the employment-related expenses for these professionals likely qualify for Medicaid administrative match at the 75 percent federal match rate. They are considered Skilled Professional Medical Personnel (SPMP), and this is an example of an enhanced match.

Once eligible activities are identified, APS and Medicaid must determine a methodology to document the time and effort APS expends on Medicaid-related functions. Following the time and effort study, the two agencies must sign a Memorandum of Understanding (MOU). The final step is to obtain approval from the Centers for Medicare & Medicaid Services (CMS).

The APS program within the Oklahoma Department of Human Services harnesses MAC as a tool for continuous improvement and strategic planning. The Director of Community Living, Aging and Protective Services in Oklahoma, shared that:

> ***"By leveraging a continuous Medicaid Administrative Claiming (MAC) strategy, our Adult Protective Services program is not only recovering eligible federal funds, we're reinvesting them directly into strengthening the very systems that protect our most vulnerable residents. These revenues are fueling smarter technology, stronger provider networks, and increased frontline capacity to respond to abuse, neglect, and exploitation."***

To learn more from Oklahoma APS about their experiences with MAC, see **Appendix B**.

Planning, Implementation, and Operations Support for Medicaid-Related Systems

Furthermore, there are opportunities for APS to secure enhanced federal funding for Medicaid-related system projects through an Advanced Planning Document (APD). The APDs detail project goals, costs, timelines, and deliverables and must be regularly updated and reported.[5] There are a variety of domains that CMS looks at from a Medicaid systems perspective; if the system to be developed falls under one of the domains, then it has the potential to be eligible for enhanced federal funding. APDs are the approval that CMS provides for the enhanced federal funding.

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[4] Administration for Community Living, Centers for Medicare & Medicaid Services, and Veterans Health Administration. No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance. https://www.medicaid.gov/medicaid/downloads/no-wrong-door-guidance.pdf

[5] Bagley, K. (2024). Accessing Enhanced Federal Funding: The APD Process. ADvancing States. https://vimeo.com/1090937804?share=copy

There are three main types of APDs: **Planning (PAPD)**, **Implementation (IAPD)**, and **Operations (OAPD)**. The federal government offers a 90 percent match for planning and implementation phases. However, after a system goes live, states receive a 50 percent match for operations until the system is certified, at which point the match rate increases to 75 percent. The Planning APD focuses on defining the project's scope, identifying gaps and potential solutions, and coordination with stakeholders. The Implementation APD builds on this, generating a project plan and budget, determining timelines and deliverables, and defining metrics and outcomes. Finally, the Operations APD supports the ongoing maintenance and operations of the system once it is live. This involves continuous reporting of outcomes and metrics, as well as revising the operating budget and staffing levels. See **Appendix C** for more information about APDs.

Critical Incident Management

Medicaid critical incident management is a system of reporting, investigating, and resolving critical incidents, such as abuse, neglect, financial exploitation, unauthorized use of seclusion, and emergency department visits. A critical incident management system is an example of an opportunity for APS to work with Medicaid to secure enhanced federal funding.[6] Not all APS work is Medicaid-related, so costs may need to be allocated across programs. Systems that support multiple programs require cost allocation methodologies approved by CMS. After implementation, CMS certifies systems based on demonstrated improvements and outcomes, like faster processing of critical incidents. Certification affects federal funding rates, with higher matches available after certification.

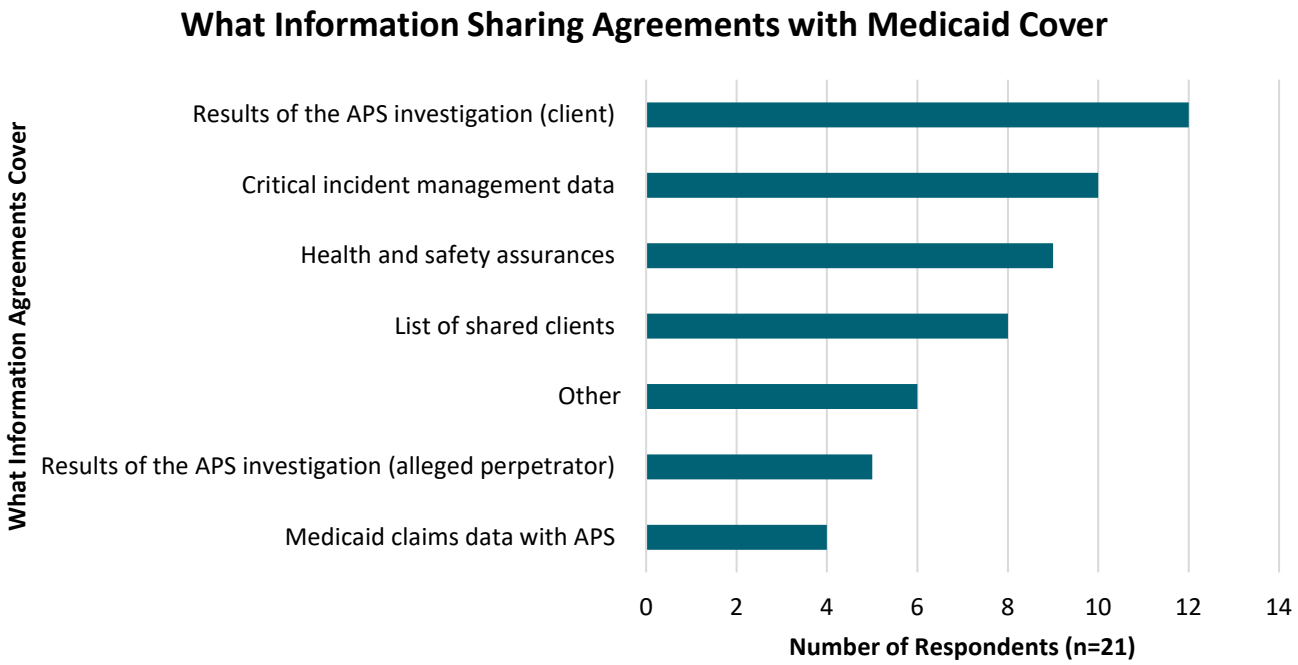
To maximize success, agencies should collaborate with the Medicaid office early, plan realistically considering other projects, and assign dedicated staff for monitoring. Additionally, if a Request for Proposal (RFP) is needed, aligning APDs with RFPs can streamline approval. A clear funding allocation methodology is essential, particularly when Medicaid eligibility is uncertain. For example, a Critical Incident Management System's development phases—planning, implementation, and operations—qualify for federal matches at varying rates, with ongoing updates potentially eligible for additional funding under an updated APD. To explore additional resources related to Medicaid financing, see **Appendix D**.

What is the purpose of an information sharing agreement with Medicaid?

An information sharing agreement is a formal MOU between two (or more) state agencies. Twenty-one states reported that they have an information sharing agreement with Medicaid and 27 states indicated that they do not. For APS programs that have an information sharing agreement with Medicaid, 12 states shared that their agreement covers the results of the APS investigation; 10 states indicated that it covers critical incident management data; 9 states reported that it covers health and safety assurances; and eight states or less shared that their agreement covers other areas, including list of shared clients, other, results of the APS investigation, and Medicaid claims data with APS (figure 3).

[6] Bagley, K. (2024). Accessing Enhanced Federal Funding: The APD Process. ADvancing States. https://vimeo.com/1090937804?share=copy

Figure 3



Description: Figure 3 is a bar chart representing responses (n=21) for what information sharing agreements cover in states that have an information sharing agreement with Medicaid. An analysis of data is in the text.

Critical Incidents

As seen in figure 3, the second most commonly reported type of information shared between APS and Medicaid is critical incident management data. In many cases, Medicaid quality assurance staff do not have background knowledge or training in investigation or substantiation. As a result, state Medicaid agencies seek partnerships to better address critical incident response and remediation. A Medicaid agency may look to APS for assistance in investigating critical incidents. Conversely, APS investigations that involve alleged abuse of a Medicaid beneficiary by a Medicaid provider need to be brought to the attention of the Medicaid agency and documented in a data management system.

Critical Incidents and Regulations

On May 10, 2024, CMS released the final Ensuring Access to Medicaid Services Rule (Access Rule).[7] These final regulations are to ensure access to Medicaid home and community-based services (HCBS). HCBS can be provided through a number of Medicaid authorities, including 1915(c) waivers, 1915(i) State Plan HCBS, 1915(j) Self-Directed Personal Assistance Services, 1915(k) Community First Choice, and 1115 demonstration waivers.[8] The Access Rule's requirements apply to all of those HCBS

[7] Federal Register. 2024. Medicaid Program; Ensuring Access to Medicaid Services. https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services

[8] ACL. 2024. The Medicaid Access Rule: A Historic Regulation to Strengthen Home and Community-Based Service. https://acl.gov/news-and-events/acl-blog/medicaid-access-rule-historic-regulation-strengthen-home-and-community#:~:text=The%20Access%20Rule%20requires%20states%20to%20institute%20and%20manage%20a,for%2Dservice%20(FFS)

authorities, unless noted otherwise in the rule, and to both fee-for-service and managed care systems. The Access Rule directs state Medicaid agencies to track and investigate allegations of abuse of Medicaid beneficiaries by Medicaid providers. State Medicaid agencies must establish a critical incident reporting system and investigate critical incidents. Medicaid can collaborate with APS or build their own investigation unit.

On May 8, 2024, the Administration for Community Living (ACL) released the Final Rule on Adult Protective Services Functions and Grant Programs.[9] These regulations became effective on June 7, 2024, and states will be required to be in compliance with these new regulations by May 8, 2028. The critical incident management provisions in the Access Rule align with the requirements codified by ACL in the APS Final Rule, promoting cross-system collaboration and information sharing. The APS Final Rule specifically includes the State Medicaid agency as a partner for APS coordination. This is to better align the APS Final Rule with the Access Rule's critical incident requirements. The Access Rule requires the states to establish a minimum definition of critical incident, including a variety of types of abuse. In fulfilling Medicaid's responsibilities to respond to critical incidents, they are likely to work with their state partners, such as APS, to investigate these abuses. The need for collaboration provides an opportunity for APS and Medicaid to work together to avoid a duplication of effort in the states.

Confidentiality Considerations

State laws vary regarding information sharing, and APS programs adhere to what state law allows them to share and with whom. In general, state confidentiality laws protect the identity of the reporter and protect client information. Additionally, the National Adult Protective Services Association (NAPSA) Adult Protective Services Recommended Minimum Program Standards is a guide for the field, outlining the minimum program standards for APS programs.[10] One of the many practice guidelines emphasizes the APS Worker's need to, "Respect the adult's right to keep personal information confidential." Considering this, in some states, there may be legal or ethical concerns related to information sharing with Medicaid.

Conclusion

Findings from the 2022 National Survey of Adult Protective Services Programs highlight the critical intersection between APS and Medicaid. The survey results show that Medicaid funds some services needed by APS clients and APS programs actively assist clients in accessing Medicaid services. While some APS programs utilize Medicaid administrative claiming (MAC), there remain opportunities to strengthen relationships with Medicaid and leverage Medicaid financing resources.

Medicaid financing offers valuable opportunities to reinforce APS programs, from program administration support via MAC to service provision for Medicaid beneficiaries. With these funding mechanisms in place, there is an opportunity for more APS programs to utilize Medicaid administrative match, highlighting the potential for increased awareness and collaboration. Furthermore, the ability to secure enhanced federal funding through Advanced Planning Documents (APDs) presents another

[9] Federal Register. 2024. Adult Protective Services Functions and Grants Programs. https://www.federalregister.gov/documents/2024/05/08/2024-07654/adult-protective-services-functions-and-grants-programs

[10] NAPSA. 2013. Adult Protective Services Recommended Minimum Program Standards. https://www.napsa-now.org/wp-content/uploads/2014/04/Recommended-Program-Standards.pdf

avenue for APS to harness Medicaid financing. Establishing cost allocation methodologies and aligning funding strategies with Medicaid requirements can help maximize these resources.

The survey also underscores the importance of information-sharing agreements between APS and Medicaid. Effective data-sharing can improve service coordination, facilitate critical incident investigations, and ensure compliance with new federal regulations, including the APS Final Rule and Medicaid Access Rule. However, differences in state confidentiality laws and program structures may pose challenges that require further collaboration and policy alignment.

By leveraging available Medicaid resources and fostering stronger partnerships, APS and Medicaid have an opportunity to improve service delivery, strengthen protections for older adults and persons with disabilities at risk of maltreatment, and create a more integrated system of care.

Appendix A

Steps in Medicaid Administrative Claiming

Medicaid Administrative Claiming (MAC)

Medicaid reimbursement is available at a rate of 50 percent match for amounts expended by a state "for the proper and efficient administration of the state plan."[11] This means that certain expenditures and activities performed by APS in support of state Medicaid long-term services and supports (LTSS) programs may be eligible for federal reimbursement at the 50 percent federal match rate for regular administrative activities, and 75 percent federal match for what is considered enhanced match.

Potentially Claimable APS Activities	
Intake and Screening	System and staffing for prompt receipt of reports of alleged adult maltreatment of beneficiaries receiving Medicaid services and the screening, prioritization and assignment of cases for follow up.
Follow-up Investigation	Information gathering to determine if maltreatment has occurred in the provision of Medicaid services, assessment of client needs to determine required services or actions necessary for an individual to be safe and remain as independent as possible.
Service Planning	Service planning with the client to improve client safety, prevent maltreatment and improve quality of life and ongoing monitoring of service plan to the extent it does not overlap with other case management activities supported by Medicaid. Coordination with Medicaid case managers in making revisions or developing a service plan for Medicaid beneficiaries.
Training	Training of APS workers on Medicaid LTSS, including eligibility rules related to Medicaid benefits and health and welfare requirements included in a state's Medicaid waivers.

To secure Medicaid administrative match, the Centers for Medicare and Medicaid Services (CMS) has identified the following steps in seeking federal reimbursement for allowable Medicaid administrative costs: [12]

- The first step is for APS to secure the support of their parent agency and engage with the state Medicaid agency.
- The Medicaid agency identifies the permissible sources of non-federal funds. In other words, they identify the sources of funds for the state portion that will be matched with the federal funds.
- The APS agency meets with the Medicaid agency to discuss the APS activities for which Medicaid administrative claiming may be possible.

[11] National Archives Code of Federal Regulations. § 433.15 Rates of FFP for administration. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-A/section-433.15

[12] See "No Wrong Door System Reference Document Medicaid Administrative Claiming Guidance" and "State Work Plan to See Federal Financial Participation for Long-Term Care Ombudsman Activities" posted on CMS web page here: https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/index.html

- After securing conceptual support from the Medicaid agency, APS and Medicaid develop a methodology to document Medicaid-related activities, for example, a time and effort study. This methodology identifies eligible and non-eligible activities and includes procedures to identify, allocate, document and report the costs of all those activities.
- The APS agency then establishes a Memorandum of Understanding (MOU) with the Medicaid agency, documenting their agreement to submit claims for federal matching funds.
- Finally, the Medicaid agency seeks approval from CMS.

Medicaid administrative claiming (MAC) can lead to several benefits, such as:

1) Creating opportunities to increase federal matching funds for state operations
2) Augmenting resources for functions already being performed
3) Strengthening collaboration and communication between APS and Medicaid
4) Developing clear policies and procedures that help connect APS clients with a wide range of services

Appendix B

Reinvesting for Results: How Oklahoma APS Uses MAC to Support Growth

The Adult Protective Services program within the Oklahoma Department of Human Services harnesses Medicaid administrative claiming (MAC) as a tool for continuous improvement and strategic planning. Oklahoma APS carefully maps out how to maximize impact back for their program, and MAC is a critical piece in how they grow stronger.

Discovering the Possibilities

When it comes to exploring possibilities with MAC, it is critical to communicate and coordinate with an array of partner agencies. Oklahoma APS connects with the Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS), the Oklahoma Healthcare Authority (the agency that manages their state Medicaid plan), other states, ADvancing States, and the National Adult Protective Services Association (NAPSA). This allows them to discover and learn about what opportunities are available and to assess the next best opportunity for them within their system.

In leveraging MAC, agencies must identify activities eligible for claiming. Oklahoma APS explored possibilities around person-centered options counseling (PCOC). In Oklahoma, roughly 50 percent of APS cases are traditional investigations for maltreatment, and 50 percent are people experiencing self-neglect. Oklahoma APS approaches a client experiencing self-neglect as a service case. For these cases, they provide PCOC, assess Medicaid eligibility, and if Medicaid-eligible, then determine how they can enhance and expand support for the person. With MAC, many activities associated with PCOC are compensable. Components of PCOC for Oklahoma APS include: a robust risk, needs, and goals assessment; a statewide service directory; automation of service planning options; and Medicaid HCBS as the central service. Additionally, PCOC is part of traditional investigation and service planning, and these clients are often eligible for Medicaid as well. When APS workers are assessing Medicaid or working with someone who is Medicaid eligible and doing PCOC, every activity is eligible for MAC.

Additionally, for Long Term Care Investigations, APS requests the face sheet from the nursing facility. This document includes the Medicaid number for individuals receiving Medicaid. The proportion of Medicaid recipients is then used to calculate the MAC rate. Wherever this data is available, it offers a complete picture of the number of Medicaid recipients being served.

Random Moment Sampling and System Improvement

To make use of MAC, agencies must also establish the amount of time spent on Medicaid related activities. Oklahoma APS uses random moment sampling (RMS) for their time study.[13]

Referencing the NWD Medicaid Administrative Claiming Workbook Tool Five: Code Development Guidance, Oklahoma APS created a detailed process map embedded within their RMS to help staff

[13] Note that a different method is used for their Long Term Care Investigation unit, in which they collect the face sheet when they go into the facility. The face sheet has the Medicaid number, which they then enter into their system to generate a report. The MAC match for that program is based on the percentage of vulnerable adults on Medicaid.

select the correct code for their work. The purpose of the process map is to report accurately and optimize their ability to claim. The process pulls out all the Medicaid related activities in an easy yes/no fashion within their RMS.

To improve the efficiency and accuracy of MAC and identify strategies for improvement, Oklahoma APS evaluates and reviews their RMS results and responses. For example, they identified that some responses from their nurses, who assess level of care for Medicaid, were going to "general paperwork activities." This was an opportunity to unpack further the category for general paperwork activities. For instance, if paperwork is linked to assessment, consultation, or reviewing or authorizing, as opposed to administrative activities, it would fall into a different cost pool that has a higher federal match. The overall restructuring of their RMS significantly supported their ability to claim Medicaid activities.

While it can be difficult to determine what activities are compensable for MAC, testing and validating can support an APS program when making that determination. Additionally, having the decision logic embedded in the survey process is key to capturing every Medicaid-compensable activity.

Reinvest in APS

MAC is a key area where Oklahoma APS can make an impact and benefit their state. As a financial lever, MAC remains a fundamental pillar of their strategy. Oklahoma APS leverages MAC, with the goal of reinvesting federal dollars to support their program. From 2019 to the projected reports for 2026, APS referrals have doubled. However, the APS workforce has not kept pace. Moreover, there are currently efforts in Oklahoma to examine positions closely and potentially downsize. With twice as many referrals and twice as much work, APS cannot afford to downsize. MAC is a way to reinvest in their program and show that they are doing the same amount of work or more work, using available state dollars efficiently.

It is important for them to have transparency in their system to justify the increased productivity and efficiency of their team. They can show impressive results; for instance, demonstrated increases in team member productivity. When the APS program demonstrates their work and results, it gives them credibility to reinvest what they have saved and to reinvest it appropriately.

Looking Ahead and Lessons Learned

The Oklahoma APS program continues to study ways to improve their MAC efforts. For example, they are exploring the possibility of a new cost allocation method for MAC, which would involve establishing a penetration rate cost pool. This method would be more straightforward and could be used for all cases, including training. Oklahoma APS views technology as a way to streamline the process of tracking Medicaid eligibility and penetration rates, potentially eliminating the need for a RMS. Oklahoma APS stressed the importance of having a system that makes data collection easy and efficient.

States need to evaluate the costs and benefits of MAC. Oklahoma APS suggests that for any large APS program, MAC is essential because it generates significant funding that can be reinvested into the program to support staffing, supplemental contracts, training programs, technology, and other critical needs. When establishing a method to document Medicaid-related time, Oklahoma advises states not to focus on an expensive RMS system or a full-time tracking system, and to keep it as simple as possible. Furthermore, when setting up an information collection system, make it easy for employees to understand what to select. If a system is set up well enough, there may be the opportunity to do straight penetration rates, which would eliminate the need for an RMS system.

As demands grow and resources tighten, Oklahoma APS's data-driven MAC strategy offers a compelling example for other states seeking to maximize the potential of MAC in APS. At its core, Oklahoma APS's use of MAC is about reinvesting in people—ensuring that those who experience abuse, neglect, or self-neglect receive the services and dignity they deserve.[14]

[14] *Special thank you to Jeromy Buchanan and Reza Zeinalpour for sharing about Oklahoma APS' experiences with Medicaid administrative claiming.*

Appendix C

Advanced Planning Document

Systems eligible for enhanced federal funding must align with Medicaid's specified domains.[15] A **critical incident management system** is an example of an opportunity for APS to work with Medicaid to secure enhanced federal funding. The federal government offers a 90 percent match for planning and implementation phases. However, after a system goes live, states receive a 50 percent match for operations until the system is certified, at which point the match rate increases to 75 percent.

Certification is a key milestone that occurs after a system has been operational for approximately six months. It involves demonstrating that the system improves key outcomes, such as faster processing of critical incidents or enhanced service delivery. Certification requires evidence that the system meets core federal requirements and generates measurable benefits. Successfully completing certification also increases the federal match for operations funding.

Not all project activities qualify for Medicaid's enhanced match rates, particularly when systems serve multiple programs beyond Medicaid. Agencies must develop a cost allocation methodology to distribute expenses appropriately. For instance, a system supporting APS cases must distinguish Medicaid-eligible activities from other work. Federal guidelines require states to coordinate with CMS to approve cost-sharing methodologies, ensuring fair allocation across funding streams.

Early collaboration with Medicaid agencies is critical during the planning process. Agencies should establish realistic timelines to avoid delays that could erode trust with CMS. Coordination is key, as system projects often intersect with other policy implementations and regulatory deadlines. Additionally, assigning dedicated staff to oversee progress and compliance is critical for ensuring smooth project execution. Early engagement and thorough planning can prevent conflicts and streamline federal approvals.

To streamline the Advanced Planning Document (APD) process, agencies should align their APD preparation with procurement plans, such as Requests for Proposals (RFPs). While RFPs are not mandatory for the initial Planning APD, they become necessary during the implementation phase. Agencies must also account for administrative requirements, including submitting updates for significant changes and ensuring timely milestone reporting. Managing these elements effectively reduces administrative burden and supports successful project outcomes.

[15] Bagley, K. (2024). Accessing Enhanced Federal Funding: The APD Process. ADvancing States. https://vimeo.com/1090937804?share=copy

Appendix D

Resources

For additional information related to Medicaid financing, readers may explore the following resources:

1. **Medicaid Administrative Claiming:** https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/index.html
2. **No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance**: https://www.medicaid.gov/medicaid/downloads/no-wrong-door-guidance.pdf
3. **NWD Medicaid Administrative Claiming Workbook:** https://nwd.acl.gov/pdf/NWD%20Medicaid%20Claiming%20Workbook%20FINAL%20July%202021.pdf
4. **NWD Medicaid Administrative Claiming Workbook Tool Five: Code Development Guidance:** https://nwd.acl.gov/pdf/NWD%20Medicaid%20Claiming%20Workbook%20Tool%20Five%20-%20Code%20Development%20%20Guidance%20FINAL%20July%202021.pdf
5. **CMCS Informational Bulletin on Medicaid Enterprise Systems Compliance and Reapproval Process for State Systems with Operational Costs Claimed at the 75 Percent Federal Match Rate:** https://www.medicaid.gov/federal-policy-guidance/downloads/cib052423.pdf
6. **Presentation on Understanding Advance Planning Documents:** https://acf.gov/sites/default/files/documents/ocse/apd_101_201_presentation.pdf
7. **CMS Advance Planning Document and Certification Library:** https://cmsgov.github.io/CMCS-DSG-DSS-Certification-Staging/
8. **Implementation Advanced Planning Document (IAPD) Template Example:** https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing-items/cms-10536
9. **Information about Streamlined Modular Certification:** https://www.medicaid.gov/medicaid/data-systems/certification/streamlined-modular-certification/index.html
10. **State Medicaid Director Letter Regarding Streamlined Modular Certification for Medicaid Enterprise Systems:** https://www.medicaid.gov/federal-policy-guidance/downloads/smd22001.pdf