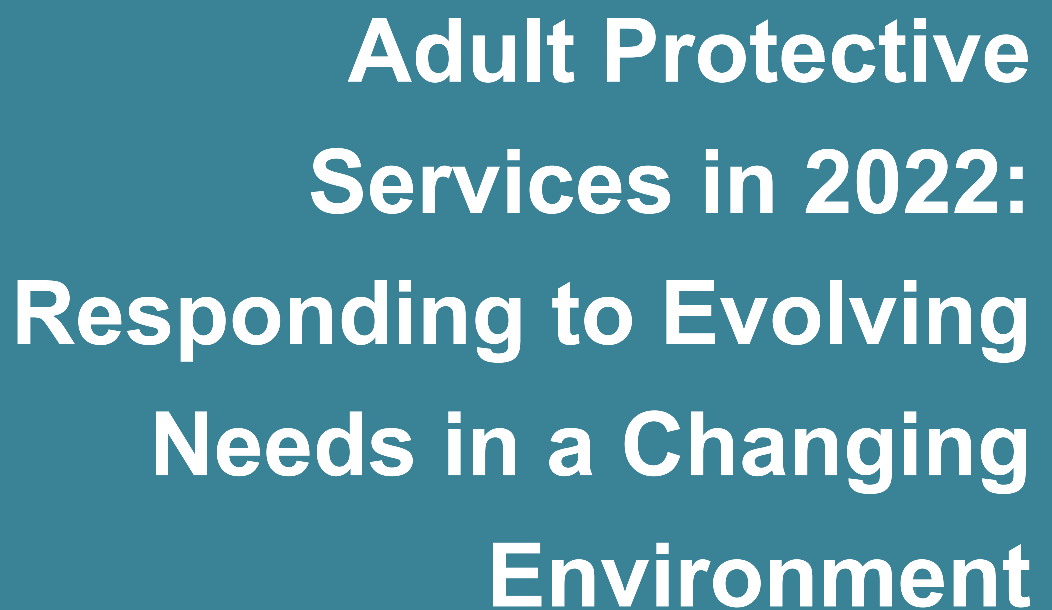

Adult Protective Services in 2022: Responding to Evolving Needs in a Changing Environment

ADVANCING STATES

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About ADvancing States

ADvancing States represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community-based services for older adults and individuals with disabilities. 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. Together with its members, the mission of the organization is to design, improve, and sustain state systems delivering long-term services and supports for people who are older or have a disability, and their caregivers.

Acknowledgements

The 2022 National Survey of Adult Protective Services Programs (APS) was designed to assess the current landscape of APS, with a special focus on people experiencing self-neglect. This survey was developed and administered by ADvancing States. Data captured in the survey reflects current opportunities and challenges for APS.

ADvancing States would like to express their appreciation to state agency staff and county APS staff for their valuable time responding to the survey. We would like to give special thanks to Kathy Morgan from Washington State APS and Mary McGurran from Minnesota APS for their expertise and guidance. Project leadership was provided by Kathy Greenlee, Senior Director of Elder Justice Initiatives, who participated in all phases of the development, implementation, and analysis of the survey. ADvancing States employees Bobbi Jo Garber and Rachel Abraham provided support with survey design, data collection, and data analysis. ADvancing States' Senior Policy Associate Samantha Gardner provided support with data analysis and report authorship.

Executive Summary

The 2022 National Survey of Adult Protective Services (APS) Programs was designed to assess the current state of APS programs and identify trends related to topics such as caseload, staff retention, and client assessment. Additionally, there was a special focus placed on clients experiencing self-neglect. Since the prior ADvancing States APS report was published, Adult Protective Services in 2012: Increasingly Vulnerable, the field of APS has experienced a variety of new opportunities and challenges. To name a few, there has been an increase in federal assistance and guidance to APS programs; there is now a national APS data collection initiative; APS programs navigated changes to practice due to the COVID-19 global pandemic; and states received an unprecedented amount of funding from mandatory, non-competitive, federal grants, in response to COVID-19. With these new opportunities and challenges, it is clear that APS are responding to the needs of their clients in an evolving environment.

This report is divided into three sections. Section one describes programmatic elements of APS. Section two focuses on the people that APS serve and identifies needed services. Lastly, section three centers on Medicaid and explores opportunities to expand APS' relationship with Medicaid.

Eight key themes emerged from the 2022 National Survey of Adult Protective Services Programs:

Section 1: What is Adult Protective Services?

> **Theme 1:** APS is a distinctly state program that operates uniquely from state to state. In recent years, there has been a strong increase in federal guidance and involvement.
>
> **Theme 2:** Many programs use standardized intake screening and assessment questions, though areas in need of more consistency include conducting a standardized assessment of client needs and safety and utilizing a specialized self-neglect assessment tool.
>
> **Theme 3:** APS works collaboratively with state, county, and local agencies to resolve cases.
>
> **Theme 4:** APS staffing is relatively stable, especially given recent shifts in the general workforce due to COVID-19.
>
> **Theme 5:** There are tools available to assist APS programs with staffing, such as case weighting, establishing targets for clients per worker, and client caseload analyses. Some states use them, and others do not.

Section 2: Who are the Adult Protective Services Clients and What are their Needs?

> **Theme 6:** Allegations of clients experiencing self-neglect is the most prevalent type of maltreatment handled by APS. There is a need for services, including case management, beyond closure of APS for cases of clients experiencing self-neglect, as well as for other APS clients.
>
> **Theme 7:** States are responding to the large number of cases of self-neglect by piloting and implementing innovative approaches to respond to these clients.

Section 3: What are some APS Financing Options?

> **Theme 8:** Medicaid financing can be used to support APS, and there are opportunities to enhance and increase relationships with Medicaid. Medicaid administrative claiming can help with staffing, and Medicaid services can support APS clients.

Methodology

In 2022, ADvancing States surveyed state Adult Protective Services (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. 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 report includes data from a total of 51 APS programs.

The 2022 National Survey of Adult Protective Services Programs was designed to assess the state of APS programs and identify trends related to topics such as caseload, staff retention, and client assessment. Additionally, given the significant percentage of APS clients experiencing self-neglect, this survey specifically asked questions to learn more about APS and self-neglect. The survey was divided into the following sections:

- Section 1: APS Programs
- Section 2: State Administered APS Programs
- Section 3: APS Staff
- Section 4: Intake, Screenings, and Access to Clinicians
- Section 5: Data Sharing, Case Management, and Self-Neglect

Introduction

Adult Protective Services (APS) are social services provided by state and local governments 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. A majority of APS programs respond to reports of self-neglect. Elder abuse and self-neglect are also referred to as adult maltreatment. To intervene and protect older persons and adults with disabilities, APS works closely with clients, and a wide variety of professionals, such as community aging and disability organizations and other state agencies, such as Medicaid.

APS definitions, standards of practice, and eligibility requirements vary from jurisdiction to jurisdiction. Historically, the federal government has had a limited role in supporting APS. APS programs are shaped by state policy and have not been subject to federal rules and regulations.[1] As a result, each state has its own unique APS system, and funding streams also vary by state.

Although state APS programs vary, the standard APS practice model is consistent nationwide. APS programs receive and screen reports through an intake system, which is primarily telephonic but can also be via fax and online reporting. Once a report is accepted, APS workers conduct an investigation, the purpose of which is to assess safety and need for protective services. Both during and following an investigation, APS workers can, and often do, arrange for supportive services. When APS concludes the investigation of a case, most programs make a determination as to whether the allegations of abuse or self-neglect are substantiated. If APS has reason to believe a crime has been committed, workers will make a referral to or involve law enforcement during or at the conclusion of the investigation.

APS clients have rights that vary according to state law. APS services are voluntary and clients have the right to accept or refuse services. However, in some states clients cannot refuse to speak with APS. All states have processes in place to arrange for emergency services and referral for possible guardianship if warranted.

In 2012, ADvancing States and the National Adult Protective Services Association (NAPSA) conducted an all-state APS survey. The resulting report, Adult Protective Services in 2012: Increasingly Vulnerable, is frequently cited as a source of information about APS practice.[2] This report intends to reflect the work of APS in 2022, with a specific focus on people experiencing self-neglect.

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1 Administration for Community Living (ACL). 2022. Adult Protective Services Client Outcomes Study Summary Report.

2 NAPSRC and NASUAD. 2012. Adult Protective Services in 2012: Increasingly Vulnerable. <http://www.advancingstates.org/sites/nasuad/files/hcbs/files/218/10851/NASUAD_APS_Report.pdf>

Section 1: What is Adult Protective Services?

Adult Protective Services is a state-authorized program, and each state's laws and regulations govern the program's operations and impact areas of practice. The standard practice model includes intake, investigation, post-investigation services, and quality assurance.[3] This section explores aspects of APS programs such as programmatic tools, partnerships, and staffing.

Theme 1: APS is a distinctly state program that operates uniquely from state to state. In recent years, there has been a strong increase in federal guidance and involvement.

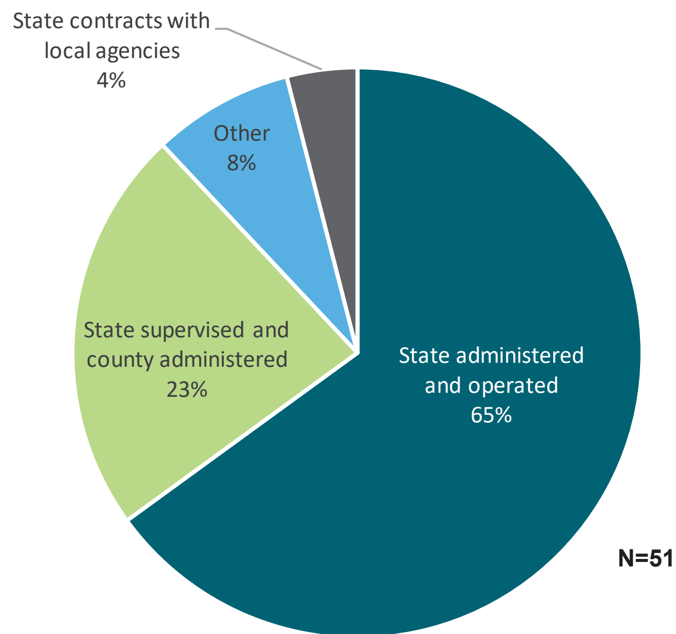
How APS Programs Are Administered

As a state-authorized program, the way in which APS programs are administered vary from state to state. The majority of APS programs are state administered and operated (figure 1). Almost a quarter of APS programs are county administered. For the eight percent who indicated "other", participants described their programs as county operated and administered; state administered and state/county operated/supervised; administered via state contract with local Area Agencies on Aging (AAAs); and state supervised and regional prosecuting attorney office administered. It is generally described that state administered programs mean that all APS staff are state employees, and county administered programs indicate that APS employees are county or regional employees.[4]

3 McGee, L. & Urban, K. (2022). Adult Maltreatment Data Report 2021. Submitted to the Administration for Community Living, U.S. Department of Health and Human Services. <http://www.advancingstates.org/sites/nasuad/files/2021%20Adult%20Maltreatment%20Report.pdf>

4 APS TARC. 2023. APS Admin 101: Resources and Information for New Adult Protective Services Administrators. <http://www.advancingstates.org/sites/nasuad/files/APS%20Admin%20101%20-%20Resources%20and%20Information%20for%20New%20Adult%20Protective%20Services%20Administrators.pdf>

Figure 1



Populations Served

Ninety percent of survey respondents reported that their APS program serves both adults 60+ and vulnerable adult clients. Ten percent said their program serves adults age 60+ only ("elder" age may vary by state). For a more detailed description of the population that APS serve, please refer to the National Adult Maltreatment Reporting System (NAMRS) data.[5]

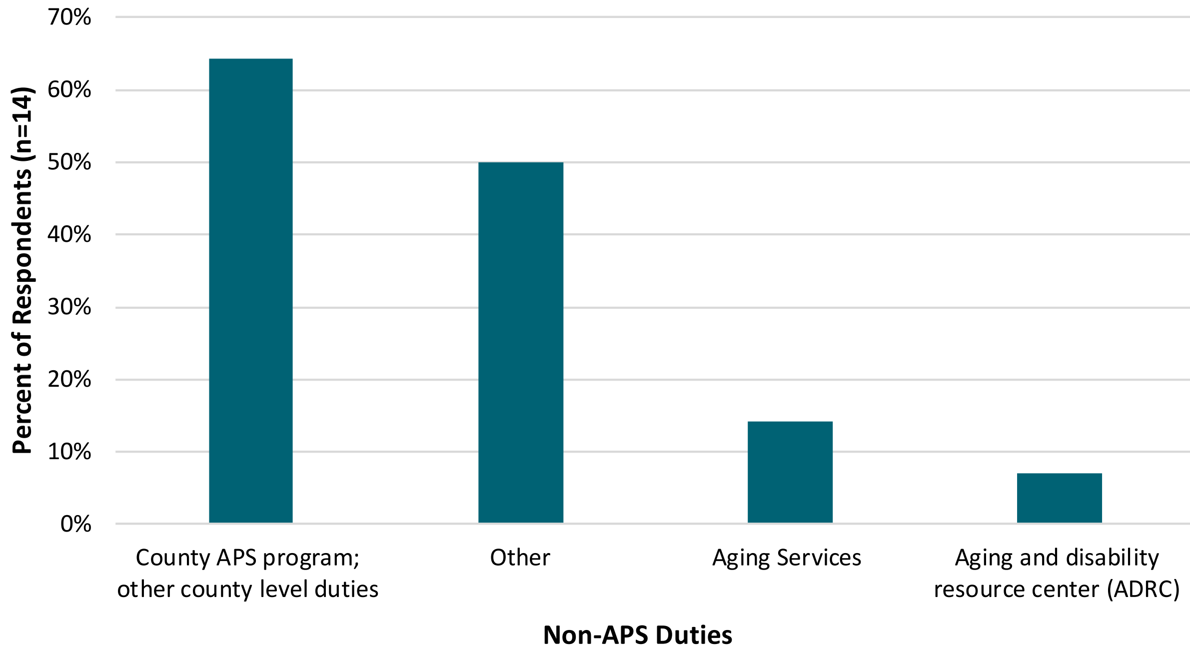
Non-APS Duties

While 73 percent of respondents said that their APS staff do not have non-APS related duties, over a quarter of respondents, 27 percent, shared that their APS staff have non-APS related duties. Notably, 10 of the 14 respondents who said that their APS staff have non-APS related duties, were programs that are state-supervised and county-administered. This data indicates that while in some states APS staff are fully dedicated to APS, this is not the case in all states. There are other duties that APS staff are taking on, and this is particularly the case in APS programs that are county administered.

Respondents who reported their staff have non-APS duties were asked to describe what the non-APS duties entail (figure 2). Sixty-four percent said that they were a county APS program and had other county level duties; 50 percent said other; 14 percent reported aging services; and seven percent indicated Aging and Disability Resource Center (ADRC). Examples of “other” responses include adult services and guardianship monitoring; public guardianship; Child Protective Services (CPS) and juvenile services casework; family, individual, conservator and disability programs; substitute decision-making; homeless services; adult residential services; unclaimed deceased adults; and supervising a family type home for adults in the community.

5 McGee, L. & Urban, K. (2022). Adult Maltreatment Data Report 2021. Submitted to the Administration for Community Living, U.S. Department of Health and Human Services. <http://www.advancingstates.org/sites/nasuad/files/2021%20Adult%20Maltreatment%20Report.pdf>

Figure 2



Furthermore, survey participants were asked if their APS program investigates child abuse allegations, to which 94 percent reported that they do not investigate child abuse allegations while six percent reported that they do. Over the last decade, this has been a significant change in the field. In a similar question from the 2012 ADvancing States survey of state APS programs, virtually all respondents reported that APS was not the sole focus of their work, and 34 percent reported working in CPS.[6] Research has previously shown that client outcomes suffer when APS staff are responsible for both APS and CPS cases.[7] This trend suggests that more state APS programs are able to solely devote their APS staff to APS cases.

Funding

State and local governments use multiple funding streams to support their APS work. Most states, 86 percent, receive state general fund appropriations for their APS program, and almost half of states use social services block grant (SSBG) funding (figure 3). Additionally, 38 percent of respondents reported using non-Older Americans Act (OAA) Administration for Community Living (ACL) grant funding. Other sources of funding for APS programs include Medicaid funding, OAA, other, county or local government, Victims of Crime Act (VOCA), other state funding sources, Department of Justice, and foundation or philanthropy.

As noted in figure 3, 18 percent of survey respondents reported that they utilize “other” funding sources; several of these other responses included recent COVID relief funding from the Coronavirus Response & Relief Supplemental Appropriations Act (CRRSA) of 2021 and the American Rescue Plan Act (ARPA) of 2021. The COVID relief funds were one time funding opportunities, and therefore impacted how states chose to spend their

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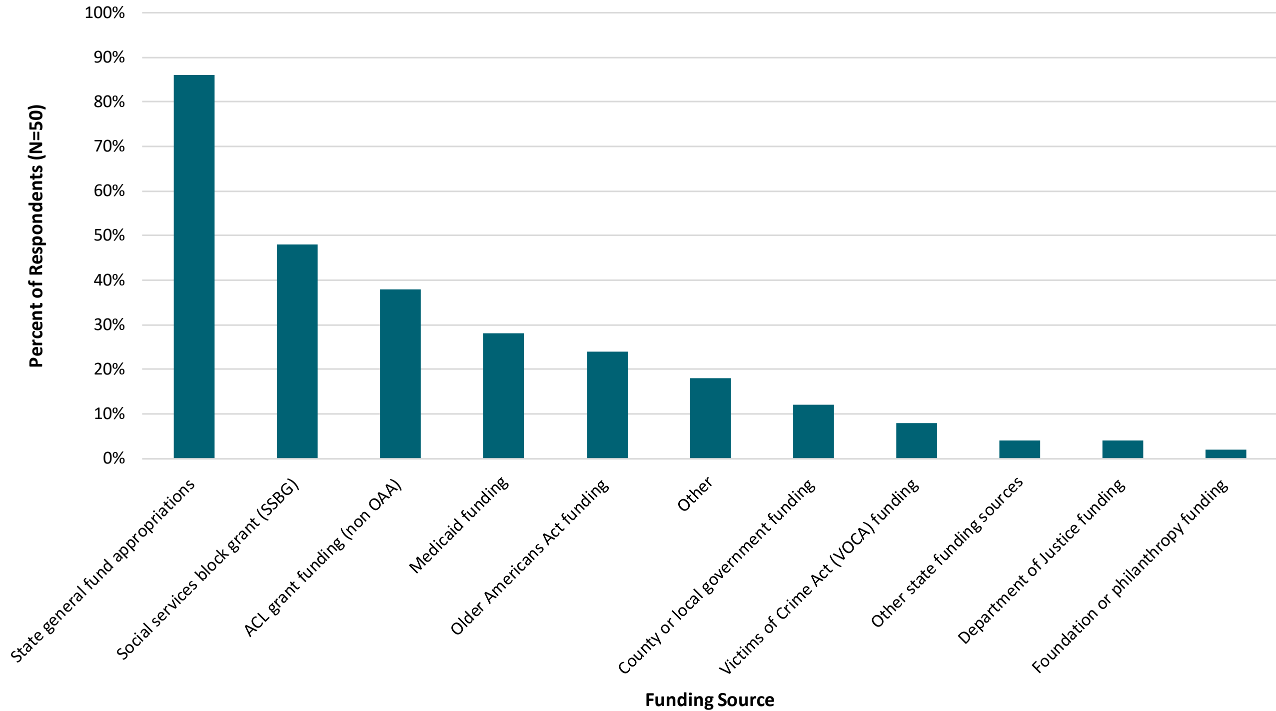
6 NAPSRC and NASUAD. 2012. Adult Protective Services in 2012: Increasingly Vulnerable. <http://www.advancing-states.org/sites/nasuad/files/hcbs/files/218/10851/NASUAD_APS_Report.pdf>

7 ACL. 2020. National Voluntary Consensus Guidelines for State Adult Protective Services Systems. <https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf>

Figure 3



funds. Unlike discretionary grants, CRRSA and ARPA were mandatory, non-competitive grants. This was the first time that formula grants were awarded to every state and territorial APS program. Furthermore, these grants represent the largest federal investment to-date in APS programs.[8] For more information about levels of funding available to states, see Appendix A.

Federal Guidance

The federal government has historically had a limited role in supporting APS programs. The passage of the Elder Justice Act (EJA) in 2010 led to changes in the involvement of the federal government in APS programs. Since 2010, the Administration for Community Living (ACL) has led federal efforts to guide APS programs. While APS is still a uniquely state program, federal guidance has increased in program administration, through efforts such as the National Adult Maltreatment Reporting System (NAMRS) and the National Voluntary Consensus Guidelines; technical assistance, through the National APS Technical Assistance Resource Center (APS TARC); and funding.

In the fall of 2023, the Office of Information and Regulatory Affairs published a proposed rule that would create federal regulations for APS.[9] The regulations are intended to establish consistent national requirements and standards. Over time, these new regulations will shape the nature of the responses we received to the 2022 survey.

8 ACL. 2021. ACL Awards Over $85 Million to Support Adult Protective Services Programs. <https://acl.gov/news-and-events/announcements/acl-awards-over-85-million-support-adult-protective-services-programs>

9 Office of Information and Regulatory Affairs. 2022. Proposed Rule: Adult Protective Services Functions and Grant Programs. <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202210&RIN=0985-AA18>

Funding

The EJA authorized ACL to provide discretionary grants to states including the Elder Abuse Prevention Intervention Demonstrations, Elder Justice Innovation Grants, and State Grants to Enhance Adult Protective Services.[10] Overall, ACL's grant portfolio has funded improvements to data collection, training, practice, and program innovation.[11]

The Elder Abuse Prevention Intervention Demonstrations fund and support projects across the country to test interventions designed to prevent elder abuse, neglect, and exploitation.[12] These projects take place in partnership with state APS agencies, State Units on Aging, and appropriate justice system entities. Additionally, the Elder Justice Innovation Grants intend to improve the field of adult maltreatment prevention and intervention, by funding projects that develop and advance knowledge and approaches about new and emerging issues related to elder justice.[13] Lastly, the State Grants to Enhance Adult Protective Services are demonstration grants awarded to states to enhance APS systems statewide in areas such as practice, services, data collection, and reporting.[14]

Additionally, as mentioned, in response to the COVID-19 pandemic, state APS programs received unprecedented amounts of funding. CRRSA and ARPA both authorized mandatory grants for APS programs. Unlike the discretionary grants, these mandatory grants were non-competitive, and funding was based on a formula to determine the allocation of grant funds.[15] The passage of CRRSA resulted in a total of $93.88 million to state APS programs.[16] ARPA allocated funds in FY2021 and FY2022. In FY21 $86.06 million were distributed to state APS programs.[17] In FY22 $163.64 million were distributed to state APS programs.[18]

Finally, in June 2023, a funding opportunity was posted in the Federal Register announcing the release of $13,829,521 in funding for APS.[19] These funds represent the first APS formula grants allocated outside of COVID-19 supplemental appropriations bills. The new funding is being released under the authority of the EJA, and the state and territorial allotment amounts are based on a formula found in section 2042(B) of the EJA. These funds are intended to support various activities such as salaries for staff; community outreach; training costs; improving APS processes; and more.

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10 ACL. 2022. The Elder Justice Act. <https://acl.gov/about-acl/elder-justice-act>

11 Petruy, E. & Dalin, H. 2020. The Future of Elder Justice. Generations: Journal of the American Society on Aging, Vol. 44, No. 1, Taking Action Against Elder Mistreatment (Spring 2020), pp. 98-100 (3 pages)

12 ACL. 2017. Elder Abuse Prevention Intervention Demonstrations. <https://acl.gov/programs/elder-justice/elder-abuse-prevention-intervention-demonstrations>

13 ACL. 2023. Elder Justice Innovation Grants. <https://acl.gov/programs/elder-justice/elder-justice-innovation-grants>

14 ACL. 2020. State Grants to Enhance Adult Protective Services. <https://acl.gov/programs/elder-justice/state-grants-enhance-adult-protective-services>

15 ACL. 2022. ACL Grants Overview. <https://acl.gov/grants>

16 Federal Register. 2021. Coronavirus Response and Relief Supplemental Appropriations Act of 2021: Grants to Enhance Adult Protective Services to Respond to COVID-19. <https://www.federalregister.gov/documents/2021/02/01/2021-02091/availability-of-program-application-instructions-for-adult-protective-services-funding>

17 Federal Register. 2021. American Rescue Plan Act of 2021: Grants to Enhance Adult Protective Services. <https://www.federalregister.gov/documents/2021/05/28/2021-11343/availability-of-program-application-instructions-for-adult-protective-services-funding>

18 Federal Register. 2022. American Rescue Plan Act of 2021: Grants to Enhance Adult Protective Services (FY 2022). <https://www.federalregister.gov/documents/2022/05/25/2022-11175/availability-of-program-application-instructions-for-adult-protective-services-funding>

19 Federal Register. 2023. Availability of Program Application Instructions for Adult Protective Services Funding. <https://www.federalregister.gov/documents/2023/06/08/2023-12248/availability-of-program-application-instructions-for-adult-protective-services-funding>

Theme 2: Many programs use standardized intake screening and assessment questions, though areas in need of more consistency include conducting a standardized assessment of client needs and safety and utilizing a specialized self-neglect assessment tool.

Standardized Intake and Assessment Questions

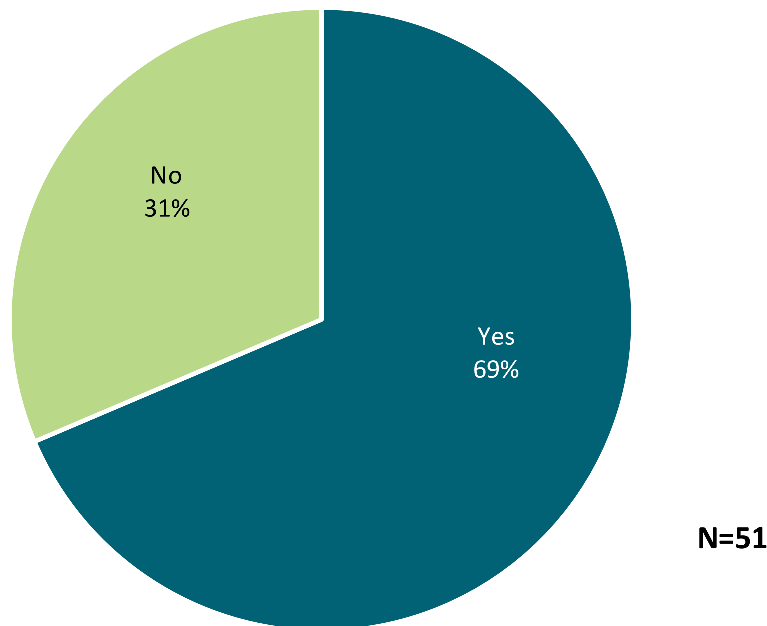
Eighty-four percent of states indicated that they use standardized intake screening questions statewide, and 16 percent said that they do not. The majority of respondents who said yes, described how they use a standard intake questionnaire in their information management system, a list of standard questions, or a script; six respondents specifically mentioned Structured Decision Making (SDM); and a few respondents said they use a proprietary intake form or utilize a centralized intake unit.

Additionally, 69 percent of respondents reported using standardized questions when conducting an assessment of client needs and safety, and 31 percent shared that they do not (figure 4). A benefit of utilizing standardized questions is that they can support uniform program application.

Specialized Assessment Tool for Self-Neglect

For people experiencing self-neglect, there are specialized assessment tools available that some APS programs are using. However, the majority of respondents, 71 percent, reported that they are not using a specialized self-neglect assessment tool (figure 5). Fourteen percent shared that they are using the Structured Decision-Making

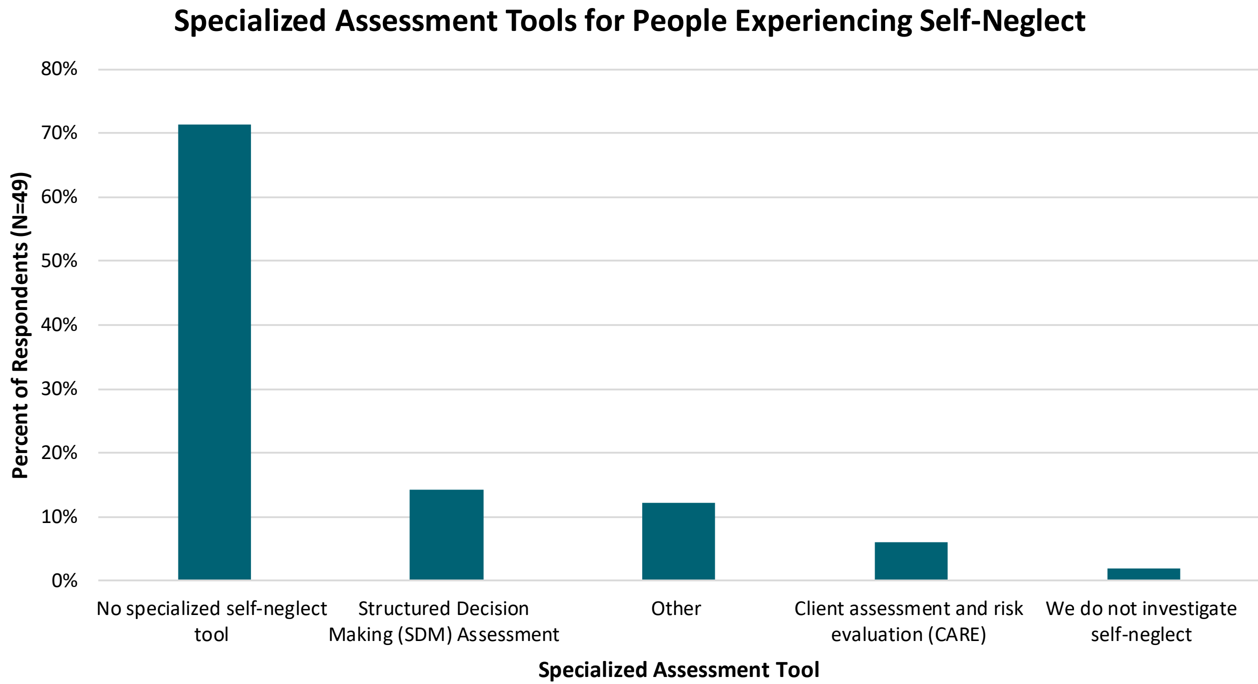
Figure 4



Assessment, 12 percent indicated other, six percent reported using the Client Assessment and Risk Evaluation (CARE), and two percent said that they do not investigate self-neglect.

As will be discussed, cases of self-neglect are a significant portion of APS caseloads. While many states do not use specialized assessment tools for people experiencing self-neglect, these tools are available to states and can support the APS programs in identifying the unique needs of people experiencing self-neglect.

Figure 5



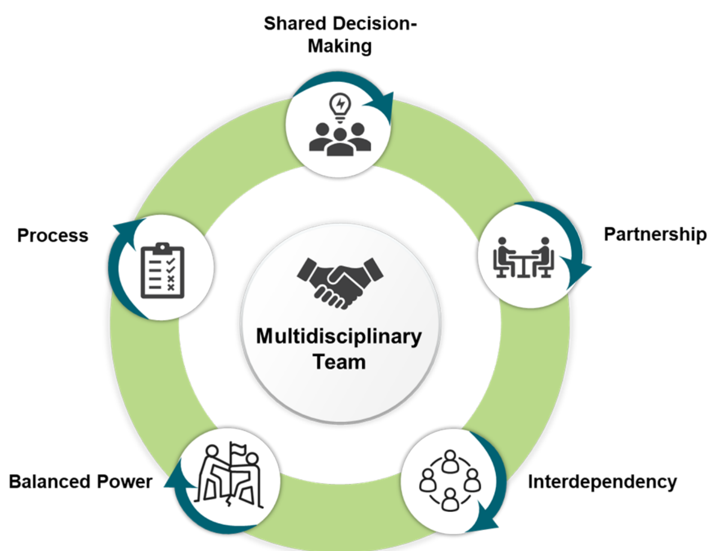
Theme 3: APS works collaboratively with state, county, and local agencies to resolve cases.

The NAPSA Adult Protective Services Recommended Minimum Program Standards is a guide for the field, outlining the minimum program standards for APS programs.[20] As stated in the NAPSA Program Standards, the goal of collaborating with other agencies and community partners is to provide comprehensive services for clients. Examples of community partners include courts and law enforcement, mental and physical health providers, domestic violence and sexual assault programs, aging and disability networks, substance abuse service providers, and tribal entities.

The Administration for Community Living published the first National Voluntary Consensus Guidelines for APS in 2016, and updated the guidance in 2020. The Consensus Guidelines recommend APS systems create policies and protocols, including development of memoranda of understanding, cross-training, and colocation of staff to promote collaboration with other entities.[21] Additionally, the Consensus Guidelines recommend states establish policies to facilitate APS participation in interdisciplinary adult maltreatment teams, which are often called Multi-Disciplinary Teams (MDTs).

Multidisciplinary Teams

In the 2022 ADvancing States APS survey, 69 percent of respondents reported that their APS program uses multidisciplinary teams (MDTs) and 31 percent shared that they do not. For those APS programs that use a MDT, 71 percent are a partner agency, 49 percent are an occasional participant as needed, and 46 percent are the lead agency. A MDT is described as a group of people from three or more disciplines who work together, have a shared goal, and is characterized by shared decision-making, partnership, interdependency, balanced power, and process.[22] Various studies have demonstrated the positive impact formal MDTs can have on the work of APS (for more information please see studies referenced in the Guidelines).[23] The Department of Justice has a Multidisciplinary Team Technical Assistance Center (MDT TAC) that provides guides, tools, and resources related to elder abuse case review MDTs. For more information, please visit: https://www.justice.gov/elderjustice/mdt.



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

21 ACL. 2020. National Voluntary Consensus Guidelines for State Adult Protective Services Systems. <https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf>

22 Department of Justice. 2016. Developing an Elder Abuse Case Review Multidisciplinary Team in Your Community. <https://www.justice.gov/elderjustice/file/938921/download>

23 ACL. 2020. National Voluntary Consensus Guidelines for State Adult Protective Services Systems. <https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf>

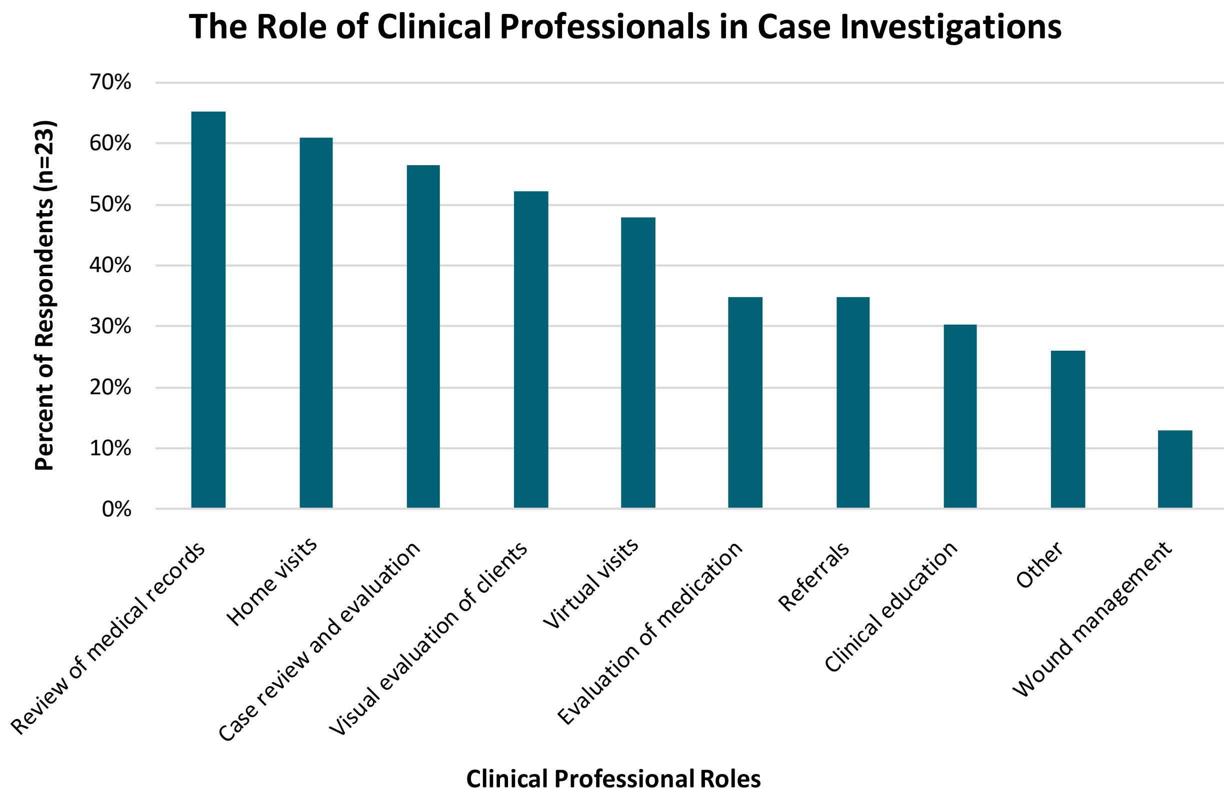
Access to Other Professionals

In relation to coordinating with other entities, in the 2022 ADvancing States APS survey, 53 percent of survey respondents indicated that their APS program does not have access to clinical assistance in case investigations for APS clients (such as nurses, doctors, psychiatrists, Advanced Practice Registered Nurses, and Licensed Clinical Social Workers); 33 percent said yes, they have a contract with clinical experts; and 14 percent said yes, they employ APS clinical staff. Additionally, survey participants reported that the types of clinical professionals that they most commonly access include Registered Nurse, Psychologist, and Medical Doctor.

Furthermore, survey respondents described the role of clinical professionals in case investigations (figure 6). Sixty-five percent of respondents indicated review of medical records; 61 percent reported home visits; 57 percent reported case review and evaluation; and 52 percent indicated visual evaluation of clients. In addition to the support provided by APS professionals, the role that clinical professionals play provide insight into the care that clients need.

While over half of respondents shared that they do not have access to clinical assistance in case investigations, states are coming up with other means to access clinical professionals. For example, with ARPA funding, all states had to submit APS Operational Plans. In these plans, many states noted using funding for consultants and clinical professionals.

Figure 6



Services – Referrals and Payment

APS also collaborates with other professionals to facilitate access to services. Referrals to other services are often needed to ensure APS clients receive the necessary supports and assistance needed. Referrals usually involve connecting clients to another service via a cold or warm hand-off. A cold hand-off generally involves transferring a client to a service/resource without making an introduction or connection for the client. A warm hand-off usually involves connecting a client to a service/resource and staying on the line until the client is introduced and connected to an individual at a referral organization.

When APS clients are in need of services, 82 percent of survey participants reported connecting them to community organizations (e.g. AAAs, Centers for Independent Living (CILs), etc.); 67 percent said they refer to Medicaid; 67 percent also said they refer to a sister state agency; 31 percent reported other; and 6 percent said this was not applicable to them (figure 7). Examples of "other" referrals include 2-1-1; ADRC; law enforcement; legal services; mental health services; long-term care ombudsman; and tribal services.

Figure 7

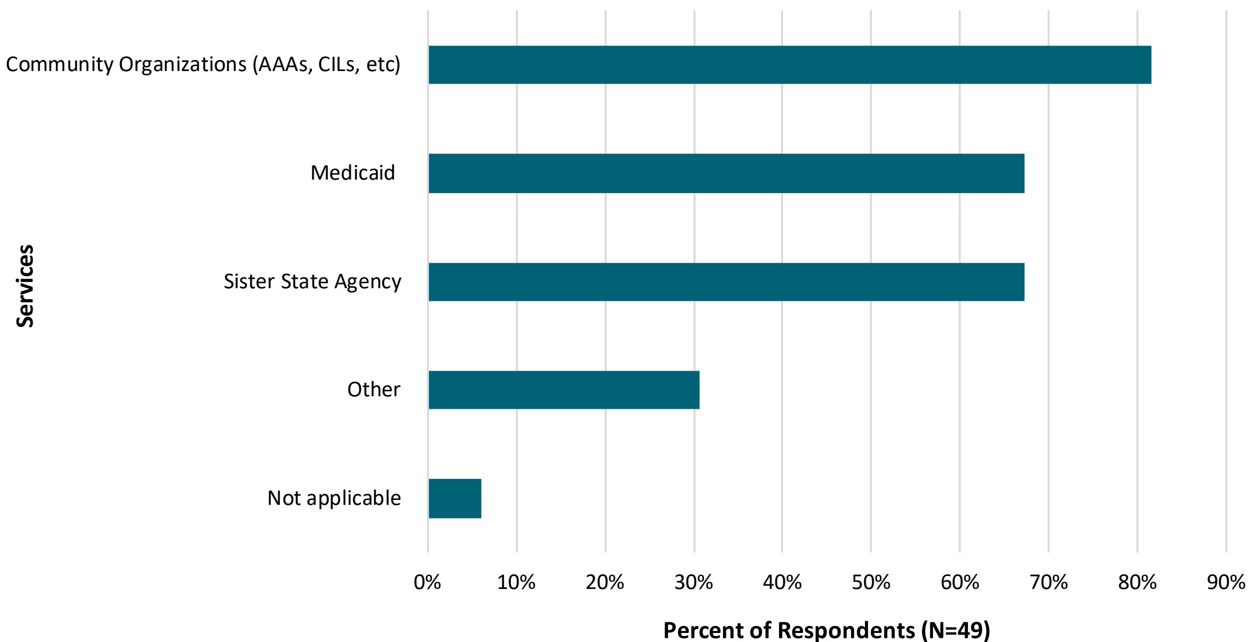
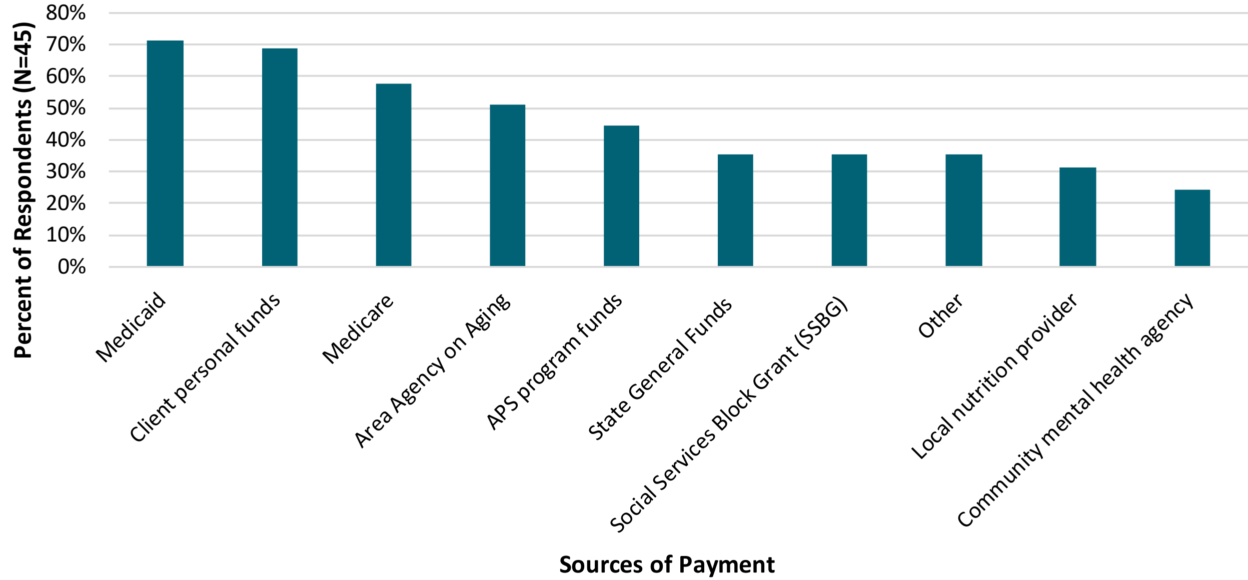


Figure 8



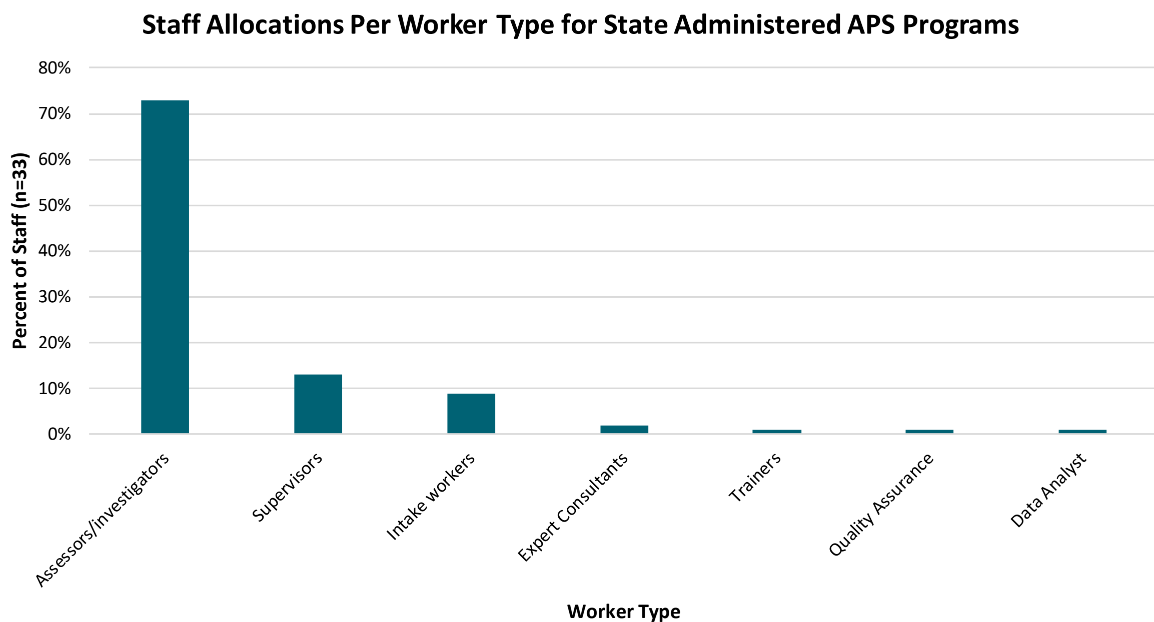
Furthermore, respondents were asked to describe for all APS clients, how the service plan services are paid for (figure 8). The top three sources of payment reported include Medicaid, client personal funds, and Medicare.

Theme 4: APS staffing is relatively stable, especially given recent shifts in the general workforce due to COVID-19.

Staff Allocations

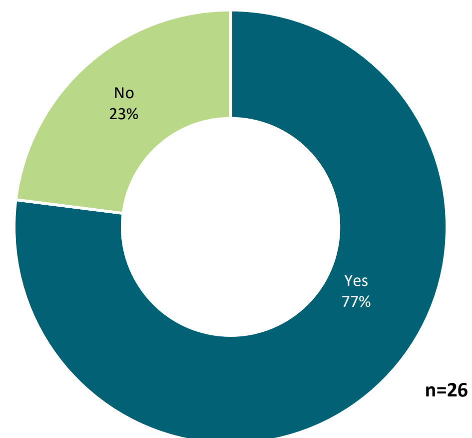
State administered APS programs were asked to describe the number of APS staff allocated to each worker type. The following bar chart is an aggregate description of the state administered APS program workforce (figure 9). As expected, assessors/investigators make up the largest sector of the APS workforce, followed by supervisors, and then intake workers. Expert consultants, trainers, quality assurance professionals, and data analysts all make up a smaller portion of the APS workforce.

Figure 9



Training is an important component of APS programs to ensure that APS workers are equipped with the necessary knowledge, skills, and abilities to best support APS clients. For state administered APS programs, 77 percent shared that they have APS staff allocated as trainers, and 23 percent reported that they do not have trainers on staff (figure 10). For programs with trainers, most states have between one and five trainers on staff. Staffing is another area where APS is allocating ARPA funds. Many states are using COVID funding to enhance training, increase permanent and temporary staff, and update curriculum.

Figure 10



Vacancy, Annual Staff Turnover, and Size of Workforce

State administered APS programs were asked to describe their current vacancy percentage rate, or the percentage of unfilled positions at their agency. Of 29 respondents, answers ranged from zero to 50 percent, with the average being 13 percent. Furthermore, for state administered APS programs, the average annual staff turnover percentage rate is 15 percent. The responses ranged from zero to 40 percent, with most respondents reporting between one and 10 percent, or 11 and 20 percent (figure 11).

Figure 11

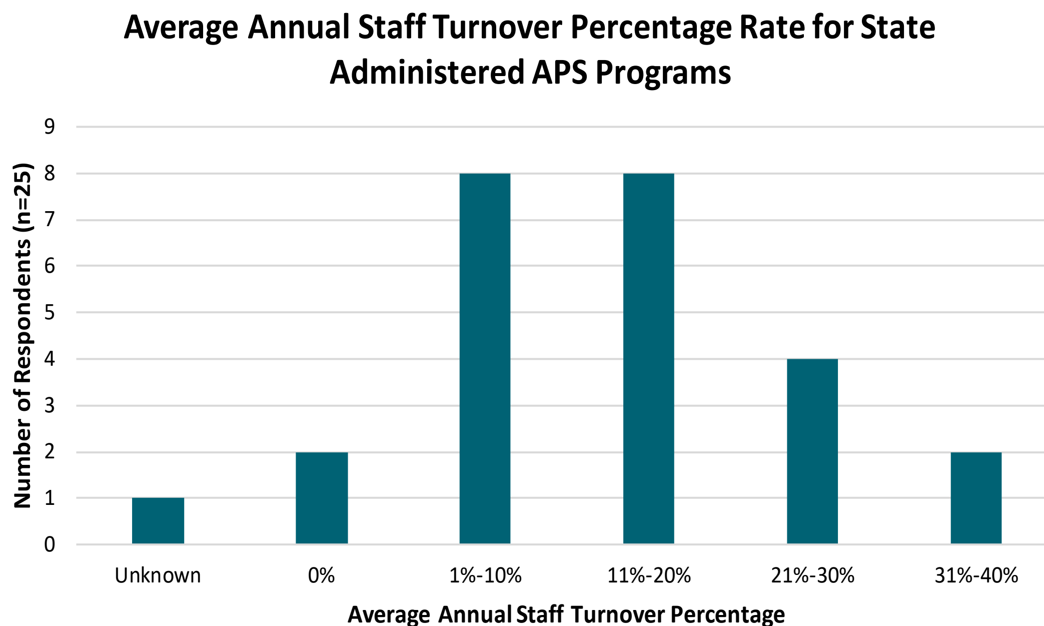
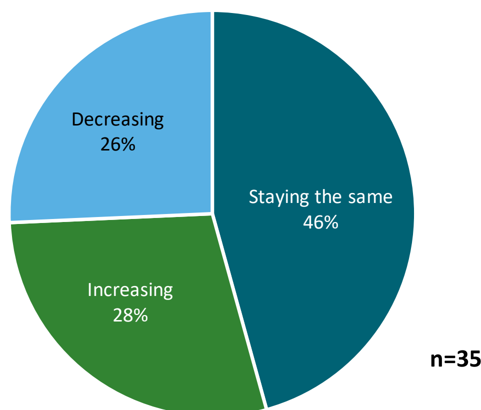


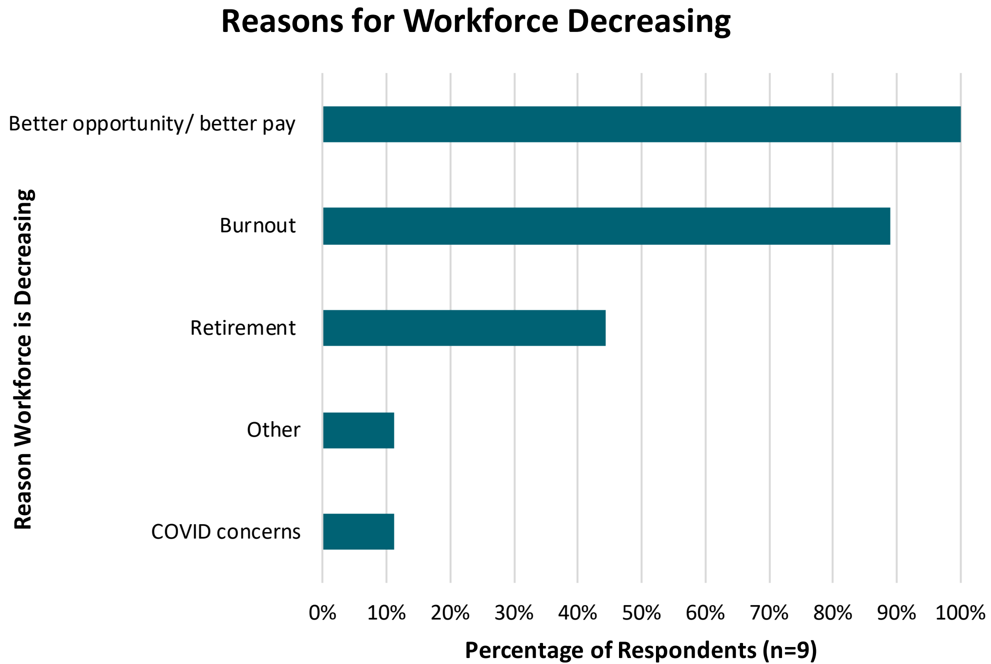
Figure 12



When asked about the size of their workforce, almost half of state administered APS programs shared that the size of their workforce is staying the same (figure 12). Twenty-eight percent said that it is increasing, and 26 percent reported that it is decreasing. This is interesting due to the widely reported "great resignation" beginning in early 2021, in which a large percentage of Americans voluntarily quit their jobs.

The state administered programs who indicated that their workforce is decreasing were asked to describe why (figure 13). All respondents reported that it was due to better opportunity or better pay. Notably, only 11 percent indicated COVID concerns.

Figure 13



Educational Background

The most frequently reported required education level for APS case investigators for state administered APS programs, reported by 91 percent of respondents, is a bachelor's degree. The next most frequently reported education level, by 18 percent of respondents, is a high school degree plus X years of experience. Furthermore, the most common educational background for case investigators, reported by 97 percent of respondents, is Social Work or related field. Forty-one percent indicated general social services, and 32 percent reported law enforcement/ criminal justice. Other less common backgrounds include behavioral health and clinical training (other than nursing). An APS program with staff primarily from a social work background will likely have a different set of skills and perspectives than a program with staff primarily from a law enforcement background.

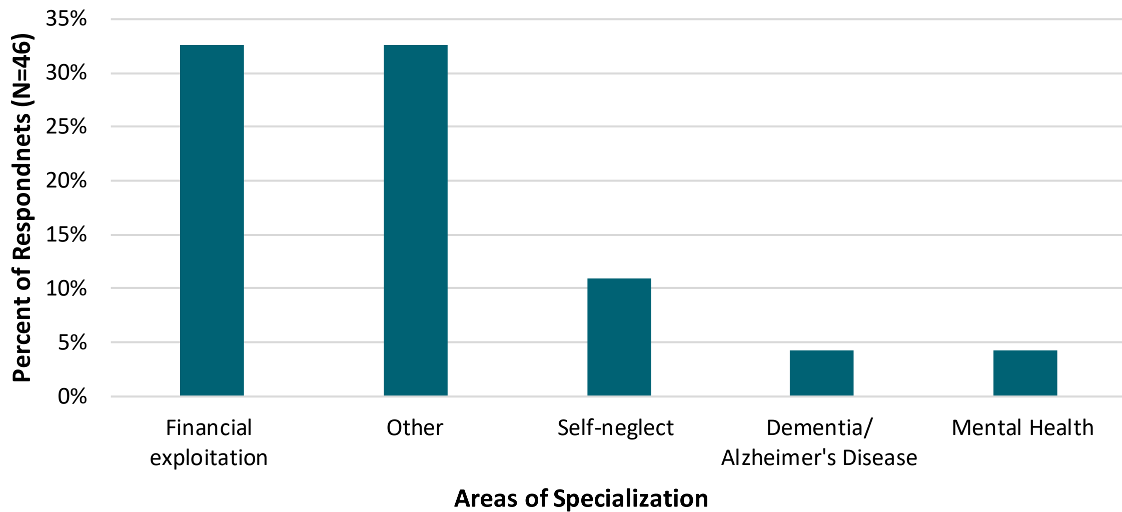
Specialized APS Staff

All survey respondents were asked if they have APS staff who are specialized and if so, what areas they specialize in. Fifty-three

percent of respondents shared that they only have generalist staff; 22 percent reported having some informally specialized staff; 22 percent also reported having a dedicated specialized unit; 20 percent shared that they have some formally specialized staff; and 12 percent indicated other. Some of the "other" respondents said that it was county dependent.

The most commonly reported areas of specialization include financial exploitation and other (figure 14). A frequently reported "other" response was guardianship; additional examples included intake, quality assurance, the homeless population, and law enforcement. A small percentage of respondents reported self-neglect, Dementia/Alzheimer's Disease, and mental health. This data provides insight into the types of APS cases that may require a more specialized set of skills and expertise.

Figure 14

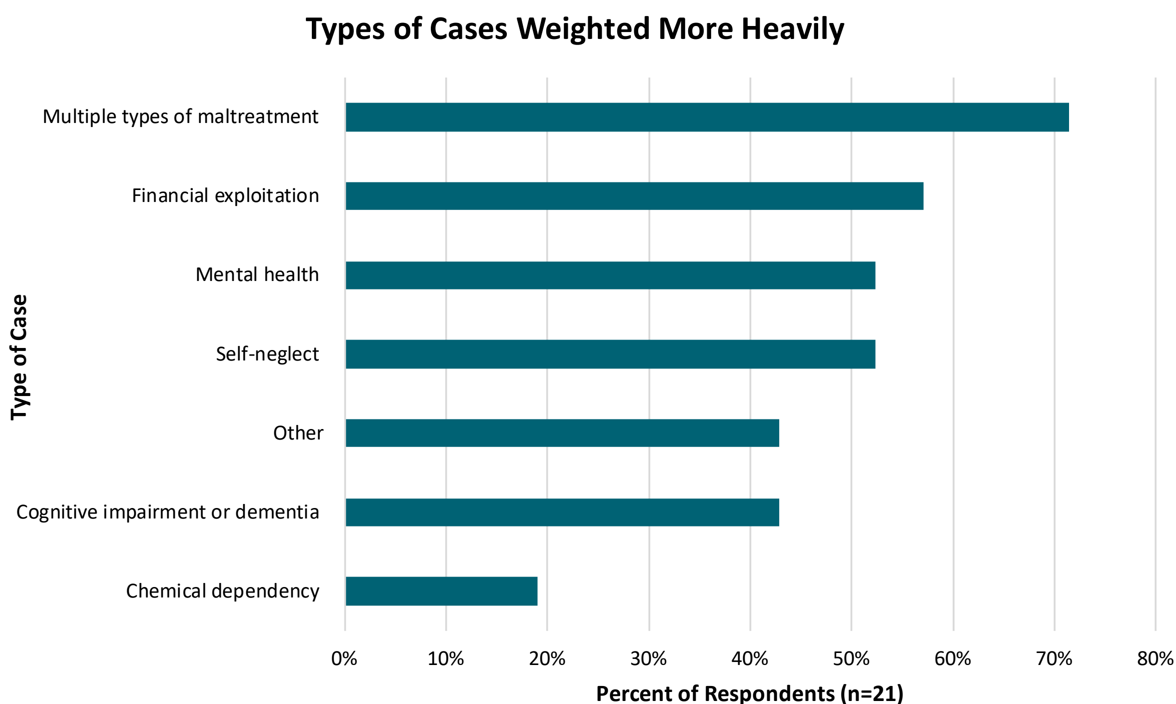


Theme 5: There are tools available to assist APS programs with staffing, such as case weighting, establishing targets for clients per worker, and client caseload analyses. Some states use them, and others do not.

Case Weighting

One strategy APS program managers use to manage workflow is case weighting based on the complexity of the case and staff preferences. Case weighting occurs when the complexity of the clients' needs are considered when assigning cases to staff. When assigning APS cases, 58 percent of survey participants reported they do not consider the complexity of the client's needs to help manage caseloads per worker, and 42 percent of respondents indicated that they do consider case complexity. Survey participants who said that they consider the complexity of the client's needs to help manage caseloads per worker were asked to indicate which types of cases are weighted more heavily. The types of cases weighted most heavily include those with multiple types of maltreatment (figure 15). This is followed by financial exploitation, mental health, and self-neglect, all of which were reported by more than 50 percent of respondents.

Figure 15



New and Open Cases Per Month

State administered APS program survey respondents were asked to describe the new cases (reports) assigned per investigator on average per month. Responses ranged from two to 40, with the average being 15 new cases per month. Additionally, on average, participants indicated that investigators handle 31 open cases per month. Responses ranged from 15 to 80 open cases per month.

Caseload Target and Analyses

In addition to asking about current practice, APS programs were asked to indicate if they have established a target for the number of newly assigned investigations (reports) per APS worker. Eighty-eight percent of survey participants reported that their APS program has not established a target for the number of newly assigned investigations per APS worker, and 12 percent said that they do have a target. While programs can create targets, assigning new investigations is dependent on the workflow and what is reported to APS. For instance, one respondent shared that they have a target of 11 new investigations per month per worker, but this target is based on current operations and program requirements. Another respondent said that they cannot create a target at this time due to budget and staff constraints.

> ***88%***
>
> ***of survey participants reported that their APS program has not established a target for the number of newly assigned investigations per APS worker***

Furthermore, APS programs were asked if they have established an open caseload target for the number of clients per worker. Seventy-one percent of respondents indicated that their APS program has established an open caseload target for the number of clients per worker, and 29 percent shared that they do not have an open caseload target. Like a target for the number of newly assigned investigations per APS worker, programs can create targets, but implementation depends on the workflow. However, an open caseload target for the number of clients per worker can assist supervisors in planning what to aim for. The National Voluntary Consensus Guidelines recommend that APS programs establish a limit on the number of cases assigned to each APS worker.[24]

Lastly, when asked if they have conducted an analysis on client caseloads of their APS staff, 78 percent of respondents reported no and 22 percent said yes. Periodic caseload studies can help APS programs determine and implement manageable ratios.[25]

24 ACL. 2020. National Voluntary Consensus Guidelines for State Adult Protective Services Systems. <https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf>

25 ACL. 2020. National Voluntary Consensus Guidelines for State Adult Protective Services Systems. <https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf>

Section 2: Who are the Adult Protective Services Clients and What are their Needs?

APS is a program designed to serve people in need of protection. 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".[26] This includes adults 18 and older with a significant physical and/or mental impairment. While APS support clients experiencing many different types of maltreatment, clients experiencing self-neglect is the most prevalent type of maltreatment. There is a need for services, such as in-home assistance and case management, amongst this population.

While the 2022 ADvancing States survey had a special focus on self-neglect, there are many other types of cases that APS encounters. To describe the general APS population, this report turns to data from the National Adult Maltreatment Reporting System (NAMRS). NAMRS collects national quantitative and qualitative data on APS practices and policies, as well as the outcomes of investigations.[27] NAMRS was established and is operated by ACL and it is the first national reporting system for APS programs.

APS investigates many types of abuse. In Fiscal Year (FY) 2021, 59.1 percent of referrals for alleged maltreatment were accepted for investigation, and of these reports, 34.2 percent had a substantiated investigation.[28] Of the reports accepted for investigation, the allegation types included: 50 percent self-neglect; 24.2 percent neglect; 24.2 percent exploitation; 12.7 percent physical abuse; and 1.5 percent sexual abuse (note there can be multiple types of allegations in an investigation). Over 75 percent of APS clients and clients with substantiated allegations were 60 or older. The highest percentage of both clients and clients with substantiated allegations was between 75 and 84 years old. Though, depending on the maltreatment type, the highest percentage of clients with substantiated allegations falls within different age ranges.

This data from NAMRS provides a brief overview of the types of cases that APS handle and the basic age demographics of the people that APS serve. To further explore the issue of self-neglect, this report will describe findings from the 2022 ADvancing States survey.

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26 NCEA and NAPSA. Adult Protective Services, What You Must Know. <http://www.advancingstates.org/sites/nasuad/files/APS-Fact-Sheet.pdf>

27 ACL. National Adult Maltreatment Reporting System (NAMRS). <https://acl.gov/programs/elder-justice/national-adult-maltreatment-reporting-system-namrs>

28 McGee, L. & Urban, K. (2022). Adult Maltreatment Data Report 2021. Submitted to the Administration for Community Living, U.S. Department of Health and Human Services. <http://www.advancingstates.org/sites/nasuad/files/2021%20Adult%20Maltreatment%20Report.pdf>

Theme 6: Allegations of clients experiencing self-neglect is the most prevalent type of maltreatment handled by APS. There is a need for services, including case management, beyond closure of APS for cases of clients experiencing self-neglect, as well as for other APS clients.

Self-neglect is described as a person's inability, due to physical or mental impairment or diminished capacity, to perform self-care tasks, obtain necessary goods and services, manage financial affairs, and/or prevent hoarding.[29] According to NAMRS, in FY21, the number of people with substantiated cases of self-neglect was higher than all other maltreatment types combined. This is consistent with previous years as well. Additionally, "self-neglect is the only maltreatment category where the percentage of substantiated allegations is higher than the percentage of unsubstantiated allegations."[30] Since the start of the pandemic, there has been an increase in the percentage of allegations of self-neglect. The prevalence of cases of self-neglect suggests a need for further exploration on this topic.

Cases of Self-Neglect

When the ADvancing States survey was administered in 2022, almost all states, 96 percent, reported providing services to people experiencing self-neglect. Two states reported their APS program does not provide protective services to people experiencing self-neglect. Of these, one respondent said that AAAs provide protective services support, and the other participant shared that another state agency program provides assistance.[31]

Additionally, the survey asked respondents to describe the percentage of total APS clients served for what is categorized as self-neglect. The majority of respondents reported between 41 and 50 percent (figure 16). Of note, there were five respondents who indicated the total cases of self-neglect comprised between 51 and 60 percent of their cases, as well five participants who reported between 61 and 70 percent. This data demonstrates that people experiencing self-neglect comprise a large portion of APS cases.

Person-Centered Language

The language we use can have a profound impact on how others view older adults, adults with disabilities, and Adult Protective Services.

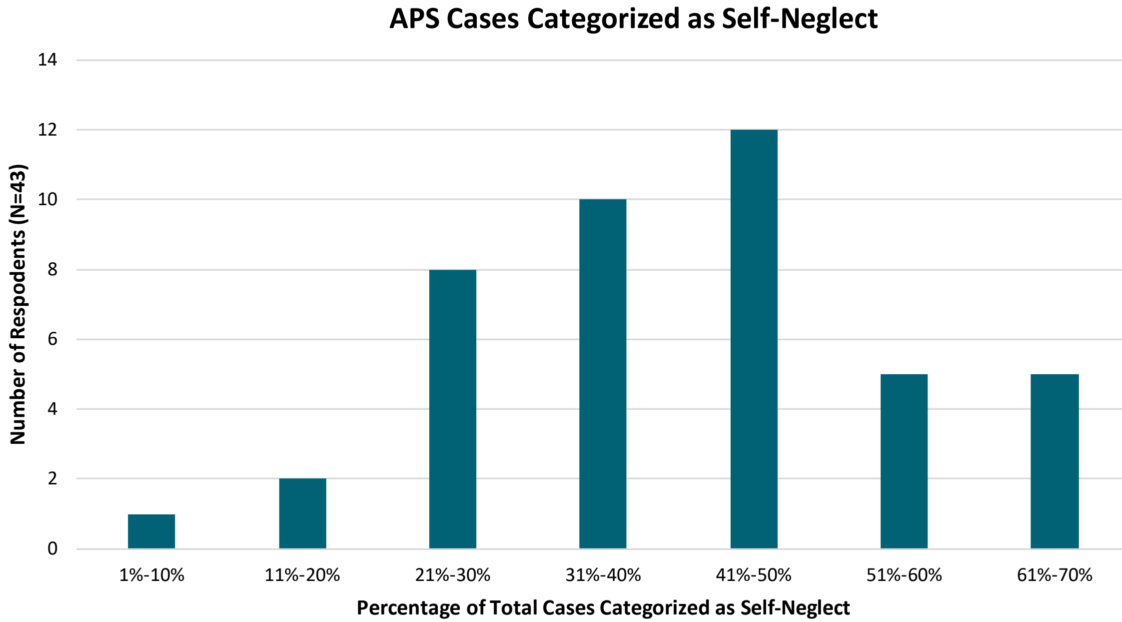
Individual choice and autonomy are critical, and these values are highlighted throughout the field, including in the NAPSA Code of Ethics and the National Voluntary Consensus Guidelines. An example of person-centered language as it relates to Adult Protective Services includes, people or clients at risk of or experiencing self-neglect.

29 McGee, L. & Urban, K. (2022). Adult Maltreatment Data Report 2021. Submitted to the Administration for Community Living, U.S. Department of Health and Human Services. <http://www.advancingstates.org/sites/nasuad/files/2021%20Adult%20Maltreatment%20Report.pdf>

30 McGee, L. & Urban, K. (2022). Adult Maltreatment Data Report 2021. Submitted to the Administration for Community Living, U.S. Department of Health and Human Services. <http://www.advancingstates.org/sites/nasuad/files/2021%20Adult%20Maltreatment%20Report.pdf>

31 Please note that the status of providing services to people experiencing self-neglect at the time of this report and the status at the time of the survey are different. For example, one of the states that reported no to providing services to people experiencing self-neglect, has since passed legislation to move responsibilities for cases of self-neglect from the state unit on aging to APS.

Figure 16

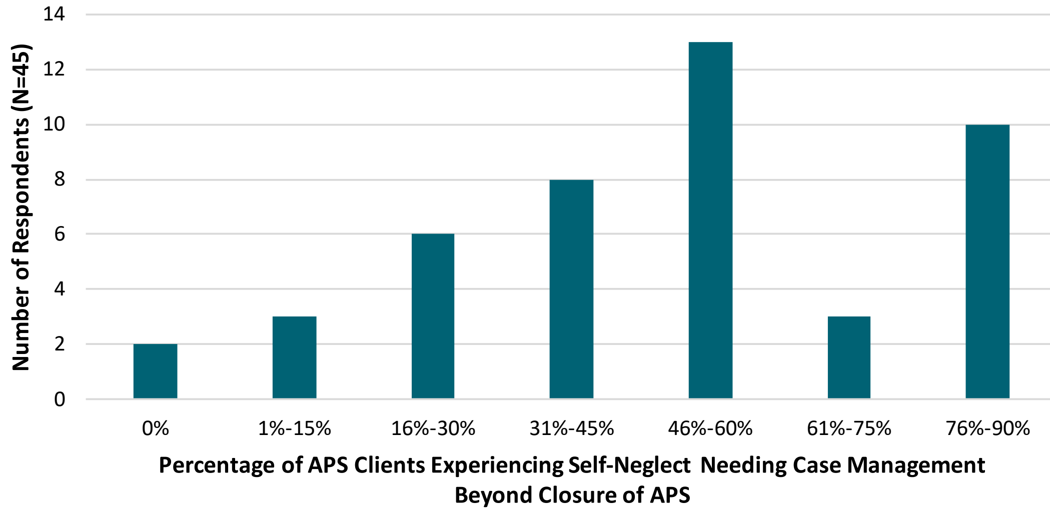


Case Management

Case (or care) management is a service that APS programs may provide to their clients. Case management generally involves identifying, accessing, and coordinating services to support clients. Seventy-eight percent of respondents indicated that they provide case management, though the duration of case management differed amongst respondents. Most participants who provide case management indicated that the duration of case management varied by situation. Other responses ranged from less than one month to 12 months. The other 22 percent of survey respondents shared that providing case management was not applicable to them or that they did not provide case management services.

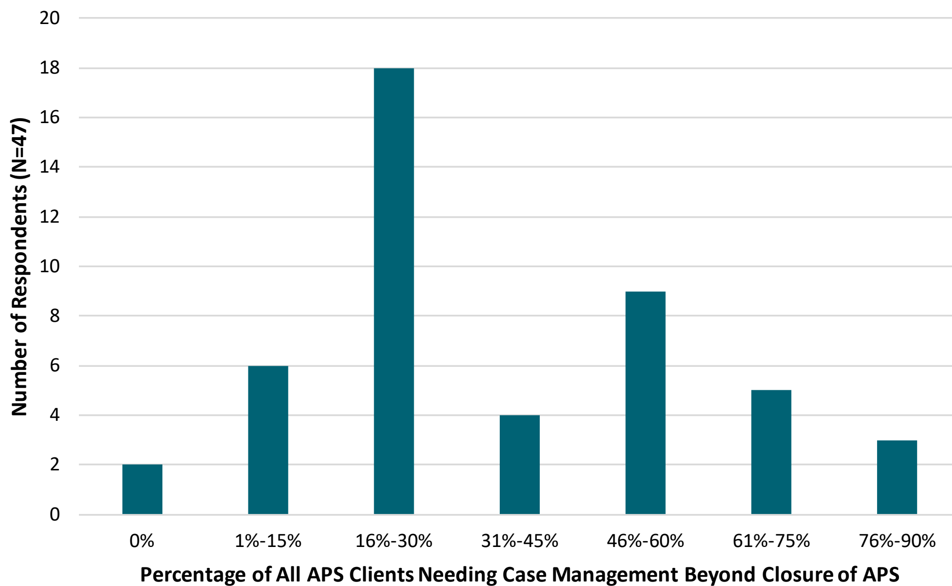
Furthermore, respondents were asked to describe the percentage of APS clients experiencing self-neglect who need case management beyond the closure of APS. **For clients experiencing self-neglect**, the most reported response, with 13 respondents, was between 46 and 60 percent (figure 17). Notably, 10 respondents reported between 76 and 90 percent of clients experiencing self-neglect needed case management beyond closure of APS. APS is designed for emergent problems and not long-term support, though characteristics of self-neglect and outcomes demonstrate the condition of self-neglect is chronic and not acute. Case management beyond the closure of self-neglect is a tool that can provide extended support that is often needed for individuals experiencing self-neglect.

Figure 17



Survey respondents were also asked to describe the percentage of all APS clients who need case management beyond closure of APS. **For all APS clients**, the most reported response, with 18 respondents, was between 16 and 30 percent (figure 18). Additionally, three respondents indicated between 76 and 90 percent of all APS clients needed case management beyond closure of APS. While the percentage of all APS clients needing case management is less than the self-neglect cases, it is clear that other types of APS clients may also benefit from case management beyond case closure.

Figure 18

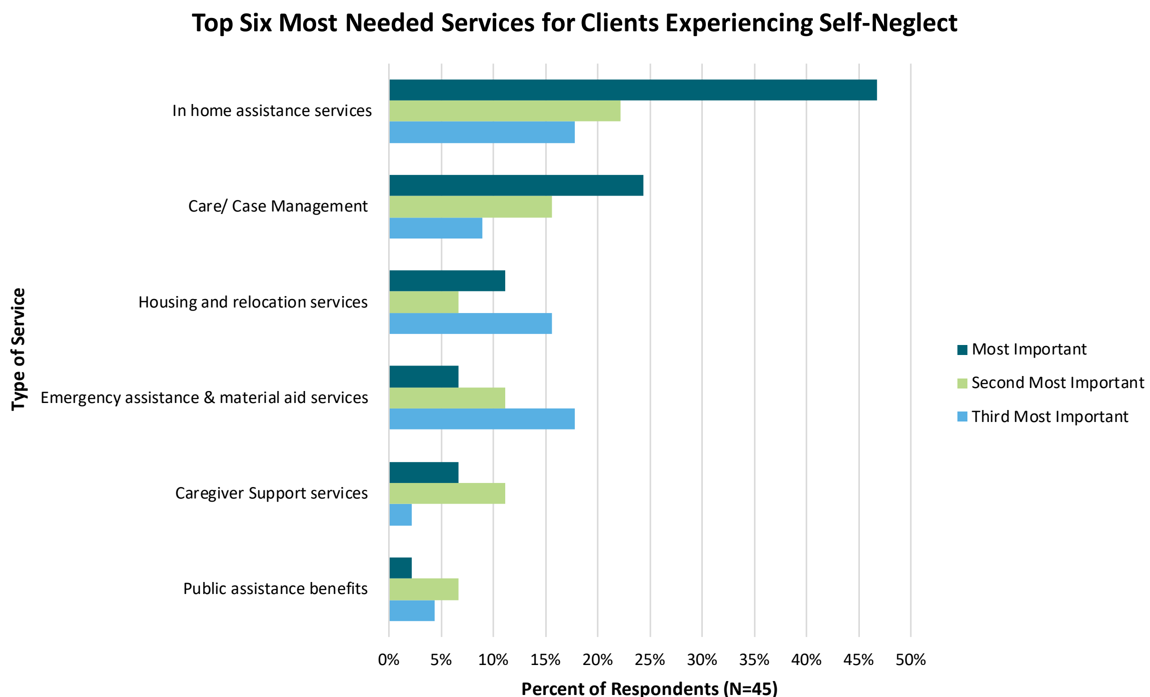


Needed Services for Clients Experiencing Self-Neglect

To better understand the needs of clients experiencing self-neglect, participants were asked to rank the most needed services for these clients, regardless of availability. The figure below includes the top six services that were ranked as first, second, and third most important in terms of need (figure 19). By far the most needed service, reported by 47 percent of respondents, was in-home assistance services (such as bathing, dressing, grooming, medication management, supervision). The next most needed service was care/case management, reported by 24 percent of respondents. In-home assistance services were also the highest ranked for second and third most important services needed (along with emergency assistance and material aid services for third most important). Of note, case management is also ranked high as a needed service, which is related to the data previously discussed where respondents reported the percentage of all APS clients as well as clients experiencing self-neglect needing case management beyond closure of APS.

Figure 19

Top Six Most Needed Services for Clients Experiencing Self-Neglect



The prevalence of self-neglect and the need for services and for case management beyond APS points to gaps in the service delivery system. For instance, AAAs and ADRCs provide valuable resources and services that can support clients before conditions may escalate to self-neglect. The prevalence of self-neglect suggests that perhaps clients are not being adequately connected to such services.

Theme 7: States are responding to the large number of cases of self-neglect by piloting and implementing innovative approaches to responding to clients experiencing self-neglect.

As mentioned, the number of people with substantiated cases of self-neglect has been consistently higher than all other maltreatment types combined.[32] Additionally, many ADvancing States survey respondents reported a need for case management beyond APS for all clients, and particularly for those clients experiencing self-neglect, thus pointing to gaps in the service delivery system. APS programs also indicated that the top two most needed services for clients experiencing self-neglect are in-home assistance services and case management.

Assessment not Investigation

Services Delivered to Clients

Restorative Justice

With that said, states are responding to the large number of cases of clients experiencing self-neglect by piloting and implementing innovative approaches to responding to clients experiencing self-neglect. APS programs reported innovations in primarily three categories: 1) assessment not investigation, 2) services delivered to clients, and 3) restorative justice.

In terms of assessment not investigation, a few survey participants discussed how they are approaching cases of self-neglect by focusing more on services, engagement, and client participation and collaboration, as opposed to a traditional investigative approach. For instance, Colorado discussed how they have implemented an Alternative Response Pilot, in which clients alleged to be experiencing self-neglect are contacted to schedule the initial visit with APS. Family or other supports can be involved in the meeting. Similarly, Minnesota reported that they are focusing on engagement and service interventions, instead of investigation, to determine responsibility for neglect. They provide policy guidance to support the engagement of caregivers in service interventions instead of placing blame for non-criminal, unintentional neglect, or lack of community supports to prevent neglect. Minnesota states that, "investigation time frames do not apply to service engagement, with policy requiring APS to keep the case open for services until the person is safe or conditionally safe with established overrides." Furthermore, Oklahoma shared that they, "changed APS policy to consider self-neglect cases as 'Service Cases' instead of investigations." This approach allows the state to manage APS workloads more efficiently as there are fewer steps required for service cases.

Another area where states are focusing their efforts for cases of self-neglect is on services delivered to clients. For example, Tennessee described how they are using ARPA funds to create a program that provides case management and emergency-specific services for clients experiencing self-neglect. North Dakota reported that they are using ARPA funds to create an emergency fund to help individuals stay at home longer. Similarly,

32 McGee, L. & Urban, K. (2022). Adult Maltreatment Data Report 2021. Submitted to the Administration for Community Living, U.S. Department of Health and Human Services. <http://www.advancingstates.org/sites/nasuad/files/2021%20Adult%20Maltreatment%20Report.pdf>

South Carolina indicated they are using ARPA funds to make home repairs, once again allowing the client to stay home longer. Likewise, New Mexico shared that they, “are soliciting a request for proposal (RFP) to establish a multi contractor contract for prevention and intervention services to include: housing and food services, utility assistance, home modifications, durable medical equipment assistance, transportation, [and] respite.”

Lastly, two states discussed how they use a restorative justice approach as it relates to cases of self-neglect. Maine described their Elder Advocate Program which includes a “warm hand off to an advocate for ongoing support and assistance, including teaming approach with natural supports and restorative justice practices.” Vermont shared that they are piloting an ACL funded grant to provide restorative justice case services in three counties.

When it comes to piloting and implementing innovative approaches to support people experiencing self-neglect, some states reported that they are using ARPA or other COVID funding to support their efforts. While states may hope to continue their practices when COVID funding subsides, this may present sustainability concerns for some.

Section 3: What are some APS Financing Options?

Medicaid is a critical program for many APS clients. While APS programs provide assistance, such as referring clients to Medicaid or assisting clients with Medicaid applications, there are additional possibilities for APS to strengthen their relationship with Medicaid. 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 may also be a source of funding for services needed by APS clients who are Medicaid beneficiaries.

Medicaid and APS often share common clients. There is increasing need for the Medicaid and APS agencies to share information. The federal government is encouraging such exchange as part of the Medicaid agency's responsibilities for critical incident management.

Theme 8: Medicaid financing can be used to support APS, and there are opportunities to support and increase relationships with Medicaid. Medicaid administrative claiming can help with staffing, and Medicaid services can support APS clients.

Medicaid Administrative Claiming (MAC)

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. Funds from MAC can be used to directly support APS programs, such as covering staffing costs or supporting case management for APS clients. APS programs were asked if they utilize Medicaid administrative match as a funding source. Twenty-seven percent reported that their APS program utilizes Medicaid administrative match.

In order for an APS program to access Medicaid administrative funds, specific steps must be taken. Appendix B 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. 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. Note, 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.

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).

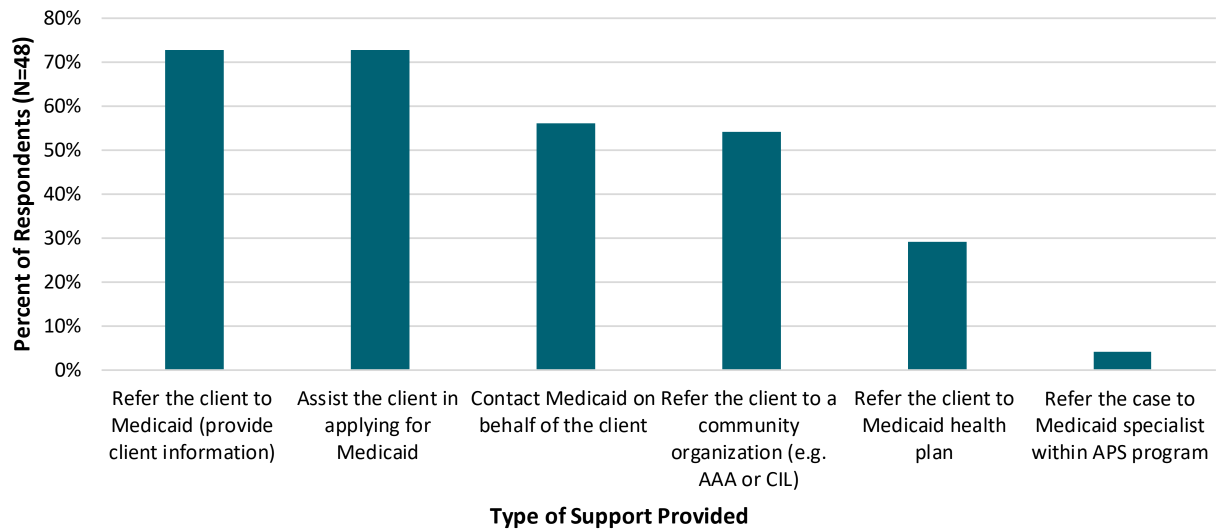
Medicaid Assistance for APS Clients

In situations where an APS client is likely eligible for Medicaid, 73 percent of participants reported that they refer the client to Medicaid; 73 percent assist the client in applying for Medicaid; 56 percent contact Medicaid on behalf of the client; 54 percent refer the client to a community organization (e.g. AAA or CIL); 29 percent refer the client to a Medicaid health plan; and four percent refer the case to a Medicaid specialist within the APS

program (figure 20).

Given that approximately half of APS cases involve a person who is Medicaid eligible, and that many states report that they refer or assist clients with Medicaid, APS clients are likely also eligible for other public benefit programs. APS programs are well positioned to educate and inform clients of other public benefit programs that can assist with healthcare costs. Clients eligible for Medicare could benefit from the Medicare Low-Income Subsidies, including the Medicare Savings Programs (MSPs) and the Part D Low-Income Subsidy (LIS)/Extra Help program. Medicaid helps cover Medicare costs through the MSPs and the LIS/Extra Help program can help low-income Medicare beneficiaries with prescription drug costs. MSP applications are processed through state Medicaid offices and LIS/Extra Help applications are processed through the Social Security Administration. More information about these programs are available at local State Health Insurance Assistance Programs (SHIP), AAAs, and ADRCs.

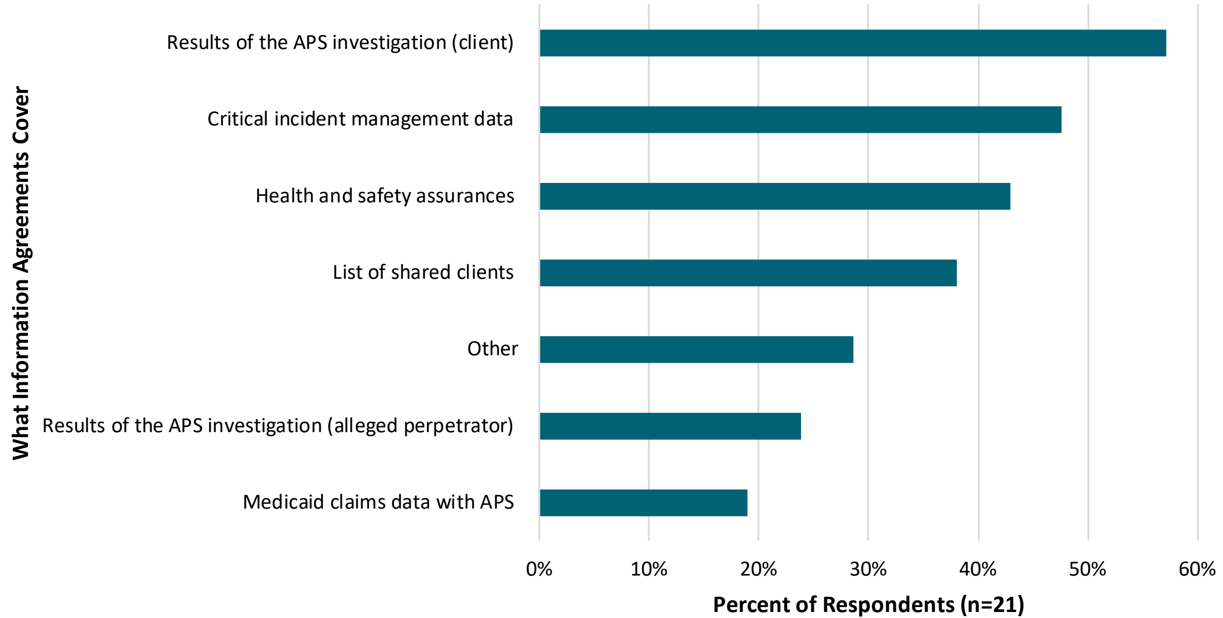
Figure 20



Information Sharing with Medicaid

An information sharing agreement is a formal MOU between two (or more) state agencies. Fifty-six percent of survey respondents indicated they do not have an information sharing agreement with Medicaid, and 44 percent shared that they do have an agreement. For APS programs that have an information sharing agreement with Medicaid, 57 percent of survey respondents shared that their agreement covers the results of the APS investigation; 48 percent indicated that it covers critical incident management data; 43 percent reported that it covers health and safety assurances; and less than 40 percent shared that it covers other areas (figure 21).

Figure 21



Medicaid Critical Incident Investigations

The second most common type of information shared between APS and Medicaid is critical incident management data, as indicated in figure 21. 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. Through guidance from CMS, the federal government has proposed to direct state Medicaid agencies to track and investigate allegations of abuse of Medicaid beneficiaries by Medicaid providers.[33] In many cases, Medicaid quality assurance staff do not have background knowledge or training in investigation or substantiation. As a result, state Medicaid agencies are seeking 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 involved 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.

33 Federal Register. 2023. Medicaid Program; Ensuring Access to Medicaid Services <https://www.federalregister.gov/documents/2023/05/03/2023-08959/medicaid-program-ensuring-access-to-medicaid-services#h-18>

Conclusion

Adult Protective Services is a unique state program that serves older persons and/or adults with disabilities who are at risk of being abused, neglected, or financially exploited, or are experiencing self-neglect. Throughout the responses to the ADvancing States 2022 National Survey of Adult Protective Services Programs, it is clear that APS is responding to the evolving needs of clients in a changing environment, partially due to opportunities and challenges as a result of COVID-19. In 2021 and 2022, APS received an unprecedented amount of federal funding in response to the COVID-19 pandemic. Furthermore, the prevalence of clients experiencing self-neglect is significant, and states are responding by piloting and implementing innovations to support this population. Additionally, the APS workforce is relatively stable, and APS continues to work collaboratively with other partners to best care for their clients. To support programmatic functions, there are several tools that many APS programs utilize, and other programs may consider them to enhance their operations. While APS is a state program there has been an increase in federal guidance and support in the past decade, and there is a possibility of federal regulations for APS in the future. Finally, to continue to grow as a program, APS can seek opportunities to support and increase relationships with Medicaid.

Appendix A

APS Funding Streams[34]										
	Social Services Block Grant (FY 2020)				CARES ACT (FY 2021)	ARPA (FY 2021-2023)				APS NPRM 2023
STATE	Grant	Other Funds (Fed., state, local)	TANF Transfer	FY 2020 Total	FY 21 Award	FY 21 Award	FY 22 Award	FY 23 Supplement	ARPA Total	Projected Annual Funding
Alabama	$ 8,207,905.00	$ 16,566,458.00	$ -	$ 24,774,363.00	$ 1,367,545.00	$ 1,253,632.00	$ 2,382,193.00	$ 51,162.00	$ 3,686,987.00	$ 203,957.00
Alaska	$ -	$ -	$ -	$ -	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Arizona	$ -	$ -	$ -	$ -	$ 2,034,877.00	$ 1,865,376.00	$ 3,616,372.00	$ 77,668.00	$ 5,559,416.00	$ 295,963.00
Arkansas	$ 119,474.00	$ -	$ -	$ 119,474.00	$ 831,205.00	$ 761,967.00	$ 1,443,035.00	$ 30,992.00	$ 2,235,994.00	$ 119,940.00
California	$ -	$ -	$ -	$ -	$ 9,476,701.00	$ 8,687,314.00	$ 16,437,221.00	$ 353,011.00	$ 25,477,546.00	$ 1,379,183.00
Colorado	$ 2,072,128.00	$ 15,845,399.00	$ -	$ 17,917,527.00	$ 1,390,939.00	$ 1,274,252.00	$ 2,439,994.00	$ 52,403.00	$ 3,766,649.00	$ 205,382.00
Connecticut	$ -	$ -	$ -	$ -	$ 1,022,558.00	$ 937,381.00	$ 1,776,855.00	$ 38,160.00	$ 2,752,396.00	$ 150,599.00
Delaware	$ -	$ -	$ -	$ -	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
District of Columbia	$ 1,886,291.00	$ -	$ -	$ 1,886,291.00	$ 140,809.00	$ 129,080.00	$ 244,720.00	$ 5,256.00	$ 379,056.00	$ 19,614.00
Florida	$ 9,717,972.00	$ 49,774,455.00	$ -	$ 59,492,427.00	$ 6,896,415.00	$ 6,321,959.00	$ 12,087,354.00	$ 259,597.00	$ 18,668,910.00	$ 1,012,648.00
Georgia	$ 2,842,267.00	$ 19,464,589.00	$ -	$ 22,306,856.00	$ 2,490,713.00	$ 2,283,242.00	$ 4,377,839.00	$ 94,021.00	$ 6,755,102.00	$ 371,014.00
Hawaii	$ 517,808.00	$ 6,303,858.00	$ -	$ 6,821,666.00	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Idaho	$ -	$ -	$ -	$ -	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Illinois	$ -	$ -	$ -	$ -	$ 3,324,229.00	$ 3,047,328.00	$ 5,750,992.00	$ 123,512.00	$ 8,921,832.00	$ 486,778.00
Indiana	$ 268,428.00	$ 32,099.00	$ -	$ 300,527.00	$ 1,765,688.00	$ 1,618,610.00	$ 3,070,139.00	$ 65,936.00	$ 4,754,685.00	$ 258,460.00
Iowa	$ 179,856.00	$ 509,329.00	$ -	$ 689,185.00	$ 884,872.00	$ 811,164.00	$ 1,535,026.00	$ 32,967.00	$ 2,379,157.00	$ 129,256.00
Kansas	$ 614,445.00	$ 9,155,185.00	$ -	$ 9,769,630.00	$ 768,741.00	$ 704,707.00	$ 1,334,740.00	$ 28,666.00	$ 2,068,113.00	$ 112,609.00

[34] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services. 2021. Social Services Block Grant Program Annual Report 2020. <http://www.acf.hhs.gov/programs/ocs/programs/ssbg> ACL. 2023. Elder Justice Act Mandatory Grants. <https://acl.gov/grants/elder-justice-mandatory-grants>

ACL. 2021. Adult Protective Services under SSA Title XX Section 2042(b) FY 2021 Allocation. <https://acl.gov/sites/default/files/grants/APC5-2021.pdf>

Federal Register. 2023. Availability of Program Application Instructions for Adult Protective Services Funding. <https://www.govinfo.gov/content/pkg/FR-2023-06-08/pdf/2023-12248.pdf>

APS Funding Streams[34]										
	Social Services Block Grant (FY 2020)				CARES ACT (FY 2021)	ARPA (FY 2021-2023)				APS NPRM 2023
Kentucky	$ 1,540,639.00	$ 13,783,675.00	$ -	$ 15,324,314.00	$ 1,216,527.00	$ 1,115,193.00	$ 2,112,929.00	$ 45,379.00	$ 3,273,501.00	$ 177,794.00
Louisiana	$ -	$ -	$ -	$ -	$ 1,211,268.00	$ 1,110,372.00	$ 2,109,473.00	$ 45,305.00	$ 3,265,150.00	$ 176,669.00
Maine	$ -	$ -	$ -	$ -	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Maryland	$ 4,755,495.00	$ 4,335,994.00	$ -	$ 9,091,489.00	$ 1,571,936.00	$ 1,440,997.00	$ 2,740,164.00	$ 58,850.00	$ 4,240,011.00	$ 234,634.00
Massachusetts	$ -	$ -	$ -	$ -	$ 1,893,433.00	$ 1,735,714.00	$ 3,289,234.00	$ 70,624.00	$ 5,095,572.00	$ 281,036.00
Michigan	$ 20,593,832.00	$ 15,276,211.00	$ -	$ 35,870,043.00	$ 2,868,691.00	$ 2,629,735.00	$4,977,667	$106,904	$ 7,714,306.00	$ 420,917.00
Minnesota	$ 987,120.00	$ 13,874,937.00	$ 187,950.00	$ 15,050,007.00	$ 1,501,422.00	$ 1,376,357.00	$ 2,622,975.00	$ 56,333.00	$ 4,055,665.00	$ 222,640.00
Mississippi	$ 2,604,296.00	$ -	$ -	$ 2,604,296.00	$ 788,509.00	$ 722,828.00	$ 1,369,378.00	$ 29,410.00	$ 2,121,616.00	$ 114,034.00
Missouri	$ -	$ -	$ -	$ -	$ 1,712,169.00	$ 1,569,549.00	$ 2,979,772.00	$ 63,996.00	$ 4,613,317.00	$ 250,009.00
Montana	$ 365,037.00	$ 2,472,676.00	$ -	$ 2,837,713.00	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Nebraska	$ 4,376.00	$ 38,466.00	$ -	$ 42,842.00	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Nevada	$ 1,971,349.00	$ 44,406.00	$ -	$ 2,015,755.00	$ 795,772.00	$ 729,486.00	$ 1,409,017.00	$ 30,261.00	$ 2,168,764.00	$ 118,424.00
New Hampshire	$ -	$ -	$ -	$ -	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
New Jersey	$ -	$ -	$ -	$ -	$ 2,401,390.00	$ 2,201,359.00	$ 4,168,871.00	$ 89,534.00	$ 6,459,764.00	$ 364,704.00
New Mexico	$ -	$ -	$ -	$ -	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
New York	$ -	$ -	$ -	$ -	$ 5,306,382.00	$ 4,864,372.00	$ 9,195,346.00	$ 197,486.00	$ 14,257,204.00	$ 799,276.00
North Carolina	$ 12,324,576.00	$ 16,902,942.00	$ -	$ 29,227,518.00	$ 2,813,974.00	$ 2,579,576.00	$ 4,937,892.00	$ 106,050.00	$ 7,623,518.00	$ 411,452.00
North Dakota	$ -	$ -	$ -	$ -	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Ohio	$ 634,000.00	$ 6,950,273.00	$ 269,630.00	$ 7,853,903.00	$ 3,319,395.00	$ 3,042,896.00	$ 5,750,910.00	$ 123,511.00	$ 8,917,317.00	$ 484,094.00
Oklahoma	$ 4,439,107.00	$ -	$ -	$ 4,439,107.00	$ 1,022,727.00	$ 937,536.00	$ 1,780,936.00	$ 38,249.00	$ 2,756,721.00	$ 148,286.00
Oregon	$ -	$ -	$ -	$ -	$ 1,212,402.00	$ 1,111,411.00	$ 2,107,701.00	$ 45,266.00	$ 3,264,378.00	$ 176,477.00
Pennsylvania	$ 5,773,803.00	$ 29,189,511.00	$ -	$ 34,963,314.00	$ 3,839,908.00	$ 3,520,052.00	$ 6,646,693.00	$ 142,749.00	$ 10,309,494.00	$ 563,289.00
Rhode Island	$ 884,902.00	$ 2,655,000.00	$ -	$ 3,539,902.00	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00

APS Funding Streams[34]										
	Social Services Block Grant (FY 2020)				CARES ACT (FY 2021)	ARPA (FY 2021-2023)				APS NPRM 2023
South Carolina	$ 14,311,707.00	$ -	$ -	$ 14,311,707.00	$ 1,490,158.00	$ 1,366,031.00	$ 2,627,163.00	$ 56,423.00	$ 4,049,617.00	$ 219,175.00
South Dakota	$ 7,732.00	$ 84,598.00	$ -	$ 92,330.00	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Tennessee	$ 5,969,012.00	$ -	$ -	$ 5,969,012.00	$ 1,842,330.00	$ 1,688,868.00	$ 3,221,883.00	$ 69,195.00	$ 4,979,946.00	$ 272,556.00
Texas	$ 36,821,160.00	$ 63,255,002.00	$ -	$ 100,076,162.00	$ 6,174,152.00	$ 5,659,858.00	$ 10,846,822.00	$ 232,954.00	$ 16,739,634.00	$ 913,978.00
Utah	$ 40,231.00	$ 123,000.00	$ -	$ 163,231.00	$ 704,100.00	$ -	$ 1,227,345.00	$ 26,359.00	$ 1,253,704.00	$ 103,721.00
Vermont	$ 492,912.00	$ -	$ -	$ 492,912.00	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Virginia	$ 1,296,078.00	$ 487,478.00	$ -	$ 1,783,556.00	$ 2,205,652.00	$ 2,021,926.00	$ 3,850,700.00	$ 82,701.00	$ 5,955,327.00	$ 325,594.00
Washington	$ -	$ -	$ -	$ -	$ 1,962,724.00	$ 1,799,233.00	$ 3,421,084.00	$ 73,474.00	$ 5,293,791.00	$ 288,858.00
West Virginia	$ 1,949,558.00	$ -	$ -	$ 1,949,558.00	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
Wisconsin	$ 1,132,666.00	$ 29,505,553.00	$ -	$ 30,638,219.00	$ 1,655,767.00	$ 1,517,845.00	$ 2,888,644.00	$ 62,039.00	$ 4,468,528.00	$ 245,790.00
Wyoming	$ 4,000.00	$ -	$ -	$ 4,000.00	$ 704,100.00	$ 645,450.00	$ 1,227,345.00	$ 26,359.00	$ 1,899,154.00	$ 103,721.00
American Samoa	$ 73,045.00	$ -	$ -	$ 73,045.00	$ 93,880.00	$ 86,060.00	$ 163,646.00	$ 3,515.00	$ 253,221.00	$ 13,830.00
Guam	$ 25,659.00	$ 447,442.00	$ -	$ 473,101.00	$ 93,880.00	$ 86,060.00	$ 163,646.00	$ 3,515.00	$ 253,221.00	$ 13,830.00
Northern Marianas	$ -	$ -	$ -	$ -	$ 93,880.00	$ 86,060.00	$ 163,646.00	$ 3,515.00	$ 253,221.00	$ 13,830.00
Puerto Rico	$ -	$ -	$ -	$ -	$ 1,037,800.00	$ 951,354.00	$ 1,802,162.00	$ 38,704.00	$ 2,792,220.00	$ 159,576.00
Virgin Islands	$ -	$ -	$ -	$ -	$ 93,880.00	$ 86,060.00	$ 163,646.00	$ 3,515.00	$ 253,221.00	$ 13,830.00

Appendix B

How To: 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".[35] 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% federal match rate.

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 to follow in seeking federal reimbursement for allowable Medicaid administrative costs:[36]

- 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.
- 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.

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35 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>

36 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>

- 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 & communication between APS and Medicaid, and 4) developing clear policies and procedures that help connect APS clients with a wide range of services.