ACL Administration for Community Living

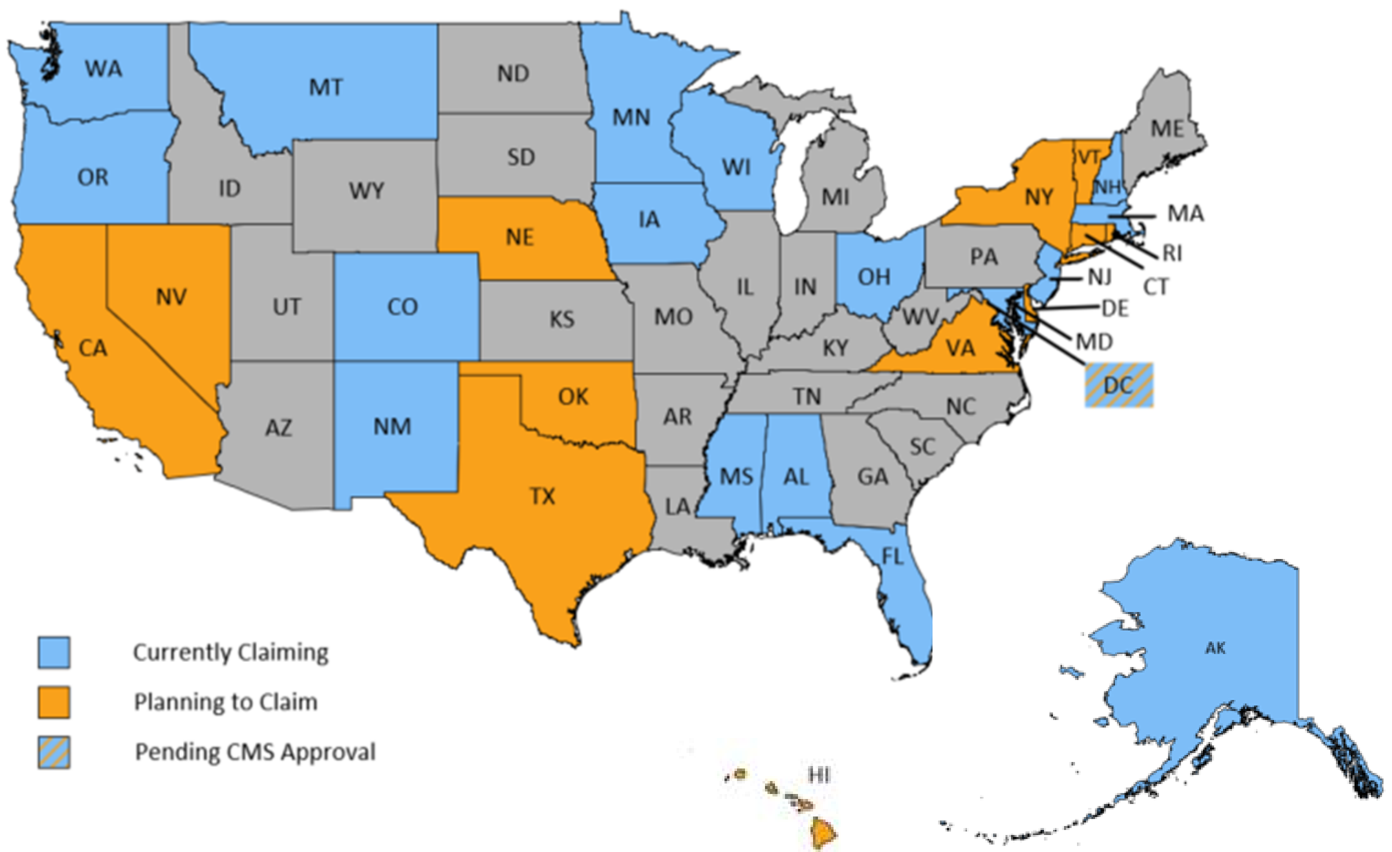
State Examples of NWD System Funding

NO WRONG DOOR

Sustaining a NWD System requires a comprehensive strategy to blend and braid various funding streams. This document provides examples of how NWD Systems use a variety of funding streams to support development and sustainability.

Medicaid Administrative Claiming

As shown in the map below, 16 states leverage Medicaid Administrative Claiming (MAC) to support their statewide No Wrong Door (NWD) System using the type of infrastructure outlined in ACL and CMS guidance. The map represents knowledge from ACL informal communication with state NWD System personnel and MAC claiming could be occurring in other states. MAC supports work explaining the Medicaid program to individuals, assisting them to make decisions about applying, gathering the necessary documents to apply, program planning, and training. State developed and specific resources are available on a private page on www.ta-community.com. *To gain access to this page, please email nowrongdoor@acl.hhs.gov.*



State General Funds

In 2019, California passed legislation to authorize the development of Aging and Disability Resource Connections (ADRCs) as a collaboration between local Area Agencies on Aging (AAA) and Centers for Independent Living (CILs). The legislation also encouraged the exploration of Medicaid administrative funding and Veterans Health Administration funding in supporting on-going development of the ADRCs program statewide. It was contingent upon appropriation of funds for this purpose.

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Veterans Health Administration Programs

Bay Aging, an AAA in Virginia, supports Veterans as a Veteran Directed Care (VDC) direct provider. They also manage the administration and finances of the program for a few other AAAs and one CIL. This hub-spoke model allows the organization to generate revenue by providing contracted financial management services (FMS) and administration. For more information, see Bay Aging's website.

Medicaid Service Dollars

The NWD System in Massachusetts supports the MassHealth Senior Care Options (SCO) program, a Medicaid managed long-term care program implemented in 2004. SCO serves older adults (age 65 and older) at all levels of disability. A primary care physician affiliated with the SCO and a team of nurses, specialists, and a geriatric support services coordinator all work with the member and family or caregivers to develop a personalized plan of care. The geriatric support services coordinator is employed by one of the state's 27 Aging Services Access Points (ASAPs) which are a part of the state's NWD System. The managed care organization (MCO) is mandated to contract with at least one ASAP in its geographic service area.

Medicare

The state of Alabama invested NWD grant funding to develop the expertise of the AAAs to screen, assess, and implement a range of interventions that address SDOH and achieve National Committee for Quality Assurance (NCQA) accreditation for case management.

The accreditation led to Medicare contracts for Alabama AAAs provide case management to individuals while in the hospital by completing needs assessments, developing person-centered plans, and coordinating care upon transition home, including medication support, coordinating medical follow-ups, and addressing other social determinants of health. The AAAs have also leveraged Medicare Advantage to fund these care transitions activities. More information on SARCOA's hospital-to-home program can be found on the TA Community website.

Health Plans

The Western New York Integrated Care Collaborative (WNYICC) is a Network Lead Entity (NLE) for a Community Integrated Health Network (CIHN) made up of six AAAs, one CIL, and 25 other community-based organizations (CBOs) serving individuals of all ages in western and central New York, part of New York's NWD System of access. WNYICC launched a regional project with a large regional Medicare Advantage plan in 2020 to provide post-discharge home-delivered meals. WYNICC coordinates with hospital discharge planners and receives daily notification of member admissions to solicit referrals and document meal delivery by their CIHN through a centralized data system managed by WYNICC. The contract has expanded in 2021 to include chronic care management, expanded meal benefit, social isolation intervention, and evidence-based programs.

Hospital Systems

In Oregon, the ADRC of Multnomah County, has a long-standing relationship with Providence Health Systems and offers hospital-to-home transitions for at-home support for up to 90 days. The ADRC receives funding for staffing of this program through a contract with the hospital system which allows full access to hospital data to use defined criteria to identify individuals who may need assistance. They are part of the Oregon Wellness Network that includes all Oregon ADRCs that are developing the same model to offer to hospitals statewide. For more information, please see the Care Transitions Peer Hour recording on the TA Community website.

Public/Private Partnerships

Connections AAA in Iowa received grant funding from local foundations to help develop its hospital transitions program over a three-year period. The program targeted individuals over 60 not eligible for Medicaid providing transition support to ensure smooth transition to home from hospital or rehab facility.

Virginia's NWD System model relies on a public/private partnership to manage and leverage their Information Technology (IT) system, Communication, Referral, Information and Assistance (CRIA), to work more efficiently, saving time and money. CRIA supports integration between government agencies and the private sector to allow secure access to personal information, with consent, track individuals served across providers, and access valuable data. Certified partners pay a fee to have access to the CRIA resource database as well as electronic referrals and case management software as needed.