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Pulling Together: Administrative and Budget Consolidation of State Long-Term Care Services

by

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Executive Summary

Consolidated State Long-Term Care Agencies

Introduction. The delivery of long-term care (LTC) services differs considerably from state to state. Currently, in most states, LTC functions and operations are dispersed throughout state government. This often results in confusion for consumers as they try to deal with a variety of programs and procedures scattered throughout many different state agencies. To ease the process of accessing LTC services and supports for consumers, many state officials are exploring several strategies, one of which includes the consolidation of LTC programs, policies, and budgets within one state agency.

Purpose. To address how a state can move toward consolidation, this discussion paper contains the following:

- An examination of a consolidated agency approach, by studying the structure of such an agency, reviewing the arguments for consolidation, and the barriers to achieving it;

- A description of how several states accomplished consolidation and the opinions of administrators in those states regarding the advantage of this structural change; and

- A checklist of steps toward consolidation to serve as a resource for state policymakers considering a move toward such a model. The checklist may assist them in sorting through the complex set of issues that are involved.

Methodology. The authors reviewed the administrative structures of five states—Minnesota, New Mexico, Oregon, Vermont, and Washington—that have either consolidated LTC policies and programs or are in the process of doing so. These five states were among the top six states in terms of their allocation of Medicaid LTC spending for home and community-based services (HCBS) compared to institutional care in FY 2004, a major goal in the five states.

Rationale for Consolidation. The ultimate purpose of a state's consolidation of its LTC system is to overcome barriers to consumer access to services and supports, and to ensure the availability of real and viable choices to consumers. Consolidating the existing fragmented program areas makes it possible for program administrators and consumers to begin thinking about LTC as a system designed to meet the changing needs of individuals, and not just a collection of separate programs.

Findings. The paper includes the following highlights:

Definition

There is no single definition of a consolidated state agency. For purposes of this project, the authors offer the following definition of a "model" consolidated state LTC agency:

> *A consolidated agency has responsibility for administration, policy, funding, and regulation for all LTC services and settings. This includes Medicaid institutional care and community-based programs, such as personal care, HCBS waiver programs, home health, hospice, Programs for All-Inclusive Care (PACE), and state-funded LTC programs, if applicable. The model structure includes the state agency on aging with its Older Americans Act programs. The model agency has responsibility for Medicaid financial eligibility determinations and responsibility for quality management for the LTC system. The agency can cover all populations of people with disabilities—older persons, other adults with physical disabilities, and persons with mental retardation/developmental disabilities. Persons with mental illness are rarely included.*

A state can have a consolidated agency that serves only older people or one that serves older persons and younger people with physical disabilities. However, some states—for example, Oregon, Vermont, and Washington—have organized their LTC systems to also include people with developmental disabilities. Each of these states phased in their consolidated agencies over time.

Components

Consolidation into one administration could include the following component parts:

- A single budget with flexibility and authority to fund an array of LTC services and supports;
- A single point of entry that does a timely and standardized assessment of financial and functional eligibility that is also used to gather hard data to manage the LTC system;
- Case management capacity to provide assistance and oversight for consumers;
- A process for resource development that meets consumer demand for services and supports;
- A fair rate setting and contracting process for providers of service;
- A structure and process for ensuring regulatory oversight and quality management throughout the system; and
- Integration of programs supported by Older Americans Act funds.

Barriers

Barriers to consolidation can include the difficulty of serving multiple populations with different issues and funding streams, agency turf battles, consumer and policymaker fears of big government, and some resistance from consumer groups.

Strategies and Stakeholders

Major state LTC system change generally requires two key elements: (1) leadership and vision reflecting core values on the part of top state policymakers (state agency officials, governors, and/or legislators); and (2) participation of major stakeholders, including consumers, providers, state officials, and individuals with disabilities and the groups that represent them.

LTC Reform

All agency directors who were interviewed for this paper agreed that it would be much more difficult to shift more money to HCBS without the consolidated structure but that many LTC reforms *can* be accomplished without the consolidation of individual agencies.

Conclusion. A consolidated agency can bring about consistent policymaking and focus the system on persons with disabilities rather than on program providers. Although many LTC reforms can occur in states without a single consolidated agency and are being developed in many states today, comprehensive system reform is much more likely to happen in states with consolidated agencies.

Introduction

> *A single agency, the Department of Aging and Disability Services (DADS), now has long-term care services as its primary function. Before the creation of DADS, long-term care consumers were served by three separate agencies, each with its own local service delivery structure. In effect, consumers faced three different (doors) into three different sets of programs and services... . (T)his fragmented, complex service delivery system resulted in consumers not receiving services best suited to their needs.*
> *__Texas Health and Human Services Commission, March 2005*

Policymakers and consumer advocates argue for expanding home and community-based services (HCBS) and supports for older Americans with disabilities to give them greater opportunity for independent living with dignity and choice. State officials have to ask themselves, however, whether the way they “do business” facilitates or impedes access to such services. In other words, does the way state governments organize the delivery of long-term care (LTC) affect access?

The delivery of LTC services differs considerably from state to state. Although the federal-state Medicaid program is the single largest public funding source for LTC, Medicaid does not require a uniform system across the country for the delivery of Medicaid LTC services. Each state can decide how best to organize and deliver these services. In many states, HCBS and supports have evolved as add-on services placed in different agencies over time.

To receive funds under the Older Americans Act, states must designate a single agency—the state unit on aging—to develop and implement a statewide aging program, including the expenditure of Older Americans Act funds for HCBS and supports. In addition to Older Americans Act programs, state aging agencies also administer HCBS programs that are funded by state general revenues, and many of these agencies also have responsibility for Medicaid HCBS waiver programs for elderly persons and/or adults with physical disabilities. However, virtually all state aging departments lack budget authority for Medicaid programs in their departments, so they often have no policy power and influence over these services.

Currently in most states, LTC functions and operations are dispersed throughout state government. For example, a state might have the following organizational structure:

- An aging agency responsible for Older Americans Act programs, state-funded LTC programs for older persons, and Medicaid HCBS waiver programs for older people. The waiver programs allow states to waive formal Medicaid rules by targeting HCBS to specific groups, such as older persons or persons with traumatic brain injury, instead of offering these services to all persons who are eligible for Medicaid.

- A Medicaid agency covering institutional care and other Medicaid HCBS waiver programs not managed by the aging agency.

- An agency that manages LTC for persons with mental retardation/developmental disabilities and another agency for persons with mental illness and/or substance abuse problems.

- A health department responsible for quality assurance in nursing homes and other residential facilities.

- A public welfare department responsible for determining eligibility for Medicaid-funded LTC services.

The result is often confusion for consumers and providers as they try to deal with a variety of programs and procedures scattered throughout many different state agencies. To ease this process for consumers, many state officials are exploring several strategies that include the following:

- "Global budgeting" or a single budget appropriation for all Medicaid LTC services. This unified, streamlined spending authority allows a state agency to avoid the "silo" approach of separate line-item budgets for institutional services or HCBS and instead to move funds among various LTC services, depending on demand and policy choices. Global budgeting is one strategy to overcome an "institutional bias" within Medicaid and to achieve a more balanced LTC system. An institutional bias can develop because nursing home care is a mandatory service under the Medicaid program while HCBS is an optional benefit that a state can choose to cover or not, resulting in the majority of Medicaid LTC funding going toward institutional care in most states.

- Single points of entry within a state to provide information to consumers about their LTC options, to determine both functional and financial eligibility for publicly funded services, and to coordinate the delivery of such services.

- "Fast track" eligibility procedures to speed up approval processing for HCBS, so people needing immediate assistance can get services and supports in their homes rather than in nursing homes. (Most nursing homes can cover the expenses of an applicant until a sometimes lengthy process for determining Medicaid financial eligibility has been completed, an option not generally available to nonprofit community agencies that administer HCBS).

- Integrated quality assurance systems that focus on client outcomes and person-centered care rather than solely on provider licensure and regulations.

Purpose

Many policymakers and state officials believe that implementing these strategies should begin with consolidation of LTC programs, policies, and budgets within one state agency. To address how a state can move toward consolidation, this discussion paper contains the following:

- An examination of a consolidated agency approach, by studying the structure of such an agency, the arguments for consolidation, and the barriers to achieving it;

- A description of how several states accomplished consolidation and the opinions of administrators in those states regarding the advantage of this structural change; and

- A checklist of steps toward consolidation to serve as a resource for state policymakers considering a move toward such a model. The checklist may assist them in sorting through the complex set of issues that are involved.

Methodology

The authors reviewed the administrative structures of five states—Minnesota, New Mexico, Oregon, Vermont, and Washington—that have either consolidated LTC policies and programs or are in the process of doing so. These five states were among the top six states in terms of their allocation of Medicaid LTC spending for HCBS compared to institutional care in FY 2004, a major goal in the five states (see Table 1). This category includes HCBS waiver programs, personal care, and home health care. These services are provided to persons with developmental disabilities as well as to older persons and other adults with physical disabilities.

Table 1. Medicaid Long-Term Care Expenditures, FY 2004 **

State Ranking	State	Institutional Expenditures (millions)	HCBS Expenditures (millions)	% of Medicaid LTC Spending on HCBS
1	**Oregon**	**$238.6**	**$569.6**	**71%**
2	**New Mexico**	**$202.8**	**$422.5**	**68%**
3	Alaska	$107.1	$175.7	62%
4	**Vermont**	**$105.2**	**$143.4**	**58%**
5	**Minnesota**	**$1,085.1**	**$1,373.1**	**56%**
6	**Washington**	**$717.3**	**$866.1**	**55%**
National Average				*36%*

Source: Burwell, B., K. Sredl, and S. Eiken. 2005. "Medicaid Long Term Care Expenditures in FY 2004." Medstat, Cambridge, MA.
** The states chosen for this study are highlighted in bold.

The high ranking of Alaska, the other state in the top six states in funding for Medicaid HCBS, can partially be attributed to its lack of funding for institutional care facilities for the mentally retarded. Also, while Alaska has a new Division of Senior and Disabilities Services in the Department of Health and Social Services, the Division of Public Assistance still administers financial eligibility for Medicaid services.

The authors also chose the five states because they are geographically diverse, are of varying size, and are in different phases of consolidation (each state is profiled in the appendix). Officials in the five states cite the greatly increased flexibility that they believe consolidated LTC operations provides, particularly when the consolidated agency has budgeting authority to shift funds among LTC services, to increase spending on HCBS, and to improve consumer access to those services.

- Oregon and Washington each consolidated their LTC programs and policies into one agency roughly two decades ago. The single agencies in these states not only combine policy, administration, financial eligibility determination, quality assurance, and funding for all LTC services but also bring various disability populations into the same agency.

- In Vermont, the Department of Aging and Disabilities (DAD) was formed in 1988, which brought together aging services, licensing of nursing homes, and some personal care programs. A couple of years later, adult protective services was added, and then in 1996, the agency assumed responsibility for LTC policy and planning and the Medicaid budget. In 2004, under a reorganization of the Agency of Human Services, DAD joined with Developmental Services and became the Department of Disabilities, Aging and Independent Living.

- New Mexico has been phasing in a plan for a consolidated Aging and Long-Term Services Department since July 2004. The Department of Health and the Human Services Department also have LTC responsibilities, but the governor has created a subcabinet position to coordinate LTC functions until further consolidation takes place.

- In Minnesota, three divisions within the umbrella Department of Human Services administer LTC services. The directors of the Aging and Adult Services Division (AASD), Disability Services Division (DSD), and Nursing Facility Rates and Policy Division report to the same assistant commissioner of Continuing Care within the department. AASD provides services and supports to older persons; DSD serves persons under age 65 with developmental disabilities, chronic medical conditions, or brain injury. The Nursing Facility Rates and Policy Division is responsible for policy and administration of certain institutional facilities.

Rationale for Consolidation

The ultimate purpose of a state's consolidation of its LTC system is to overcome barriers to providing access and viable, real choices to consumers. Consumers currently have difficulty finding what they need. They do not know about the complete array of services or supports that may be available to them and can meet their needs, or about how to pay for such services and supports. Having a consolidated administrative structure at the state level sets the stage for establishing an accessible LTC system. Consolidating existing fragmented program areas enables program administrators and consumers to begin thinking about LTC as a system designed to meet the changing needs of individuals, and not just a collection of separate programs.

The rationale for consolidation includes the following:

- Vision. Consolidation promotes a consistent, consumer-focused vision across all LTC services and supports. This vision for LTC, often embodied in a mission statement, gives the agency purpose and objectives in replacing a provider-based system with a person-centered system. The person-centered system can be designed to meet the needs of the individual consumer rather than focusing on paying provider claims.

- Accountability. Consolidation focuses accountability for the LTC mission in one administrative unit, making one agency responsible for programs, budgets, and outcomes of the entire system. This helps to reduce or eliminate competition among agencies over program budgets. The common goal becomes supporting consumer needs rather than arguing for specific program budgets.

- Consistent Policymaking. Consolidated administration can focus on building systems of services and supports, and developing the infrastructure across programs to provide cost-efficient and effective supports. The single agency is responsible for all services and supports programs and making them work together to serve a common purpose.

- Global Budgeting. Consolidation and global budgeting facilitate consumer choice and access to a variety of LTC service options by allowing program administrators to move LTC dollars among institutional and community-based programs. Global budgeting gives responsibility for the budgets of all LTC programs to a single administrative unit. It allows the financing to follow clients through the system as their needs and preferences change over time.

- Access to Services. Consolidation reduces confusion by consumers, advocates, and policymakers because it provides one place at the state level to contact to resolve LTC issues. Consolidation also facilitates development of administrative consolidation at the local level. States with consolidated state-level administration are more likely to implement a consolidated (single entry point) access system at the local level.

- Administrative Simplification. Consolidation reduces the fragmentation of services for different population groups. Older persons and other persons with disabilities can often use the same administrative and service delivery system. This reduces duplicative administrative costs and allows scarce resources to be spent on services rather than administration.

- Quality Management. Consolidation facilitates the construction of an effective, efficient quality management system providing economies of scale and scope in quality management. The scope of quality management needs to extend beyond quality assurance of individual programs or services to a more comprehensive, integrated view of preferences, satisfaction, and outcomes for the individual consumer. Given this wider scope, consumers, advocates, and policymakers can measure and compare performance and outcomes across all services and supports in the state's LTC system.

- Consolidation of Regulations. A unit retains full flexibility to monitor quality and spending, in addition to managing global policy and its implementation, when regulations have been consolidated under one agency. The licensing and regulation system also benefits from interaction with a person-centered programmatic focus that then imbues its functions with much stronger consumer priorities.

Many state officials explain the reasoning behind consolidation. "You can align funding and policy," said Shirley York, director of the Disability Services Division within the Minnesota Department of Human Services. "You need flexibility with the budget," she added. She and her colleagues in the Aging and Adult Services Division do not have conflict-of-interest concerns, she said, because both divisions report to the same person.

Kathy Leitch, assistant secretary of the Washington Aging and Disability Services Administration, said, "The consolidated agency got rid of the rationale that nursing homes are an entitlement (that) we can't cut." Deborah Armstrong, secretary of the New Mexico Aging and Long-Term Services Department, said that the state's move toward consolidation provides an opportunity for "more consistent policy and better access."

James Toews, assistant director of the Oregon Department of Human Services, said that when "you put funding and regulation together, you can really shape things." He added, "I can't imagine (administering LTC services) without one agency."

Policy Questions

I. What is a consolidated state LTC agency?

There is no single definition of a consolidated state agency, but for purposes of this project, the authors offer the following definition of a "model" consolidated state LTC agency:

A consolidated agency has responsibility for administration, policy, and funding for all LTC services and settings. This includes Medicaid institutional care and community-based programs, such as personal care, HCBS waiver programs, home health, hospice, Programs for All-Inclusive Care of the Elderly (PACE), and state-funded LTC programs, if applicable. The model structure includes the state agency on aging with its Older Americans Act programs. The model agency has responsibility for Medicaid financial eligibility determinations and responsibility for quality management for the LTC system. The consolidated agency also has regulatory oversight of the LTC system infrastructure. The agency can cover all populations of persons with disabilities—older persons, other adults with physical disabilities, and persons with mental retardation/developmental disabilities. Persons with mental illness are rarely included.

A state can have a consolidated agency that serves only older people or one that serves older persons and younger people with physical disabilities. However, some states—for example, Oregon, Vermont, and Washington—have organized their LTC systems to also include people with developmental disabilities. Each of these states phased in their consolidated agencies over time. Oregon's Seniors and People with Disabilities Division is an example of a wholly consolidated agency that serves all populations of persons with disabilities (see Exhibit 1).

Exhibit 1.
An Example of a Model Consolidated Agency:
Oregon's Seniors and People with Disabilities Division

- Oregon's Senior Services Division was created in 1981 to merge the functions of the state agency on aging with the Medicaid agency that handled nursing home policy and funding. The agency became the Senior and Disabled Services Division in 1989 with the addition of LTC services for adults with physical disabilities. Responsibility for LTC supports for people with developmental disabilities was added in 2002, and the division was renamed Seniors and People with Disabilities.

- The state has also integrated all Medicaid community and institutional LTC programs at the local level through single entry point agencies consisting of area agencies on aging or county offices. Information and referral, assessment, eligibility determination, and care coordination for Older Americans Act services, Medicaid, and even food stamps are all handled by the same offices.

- A standard automated assessment is administered to all individuals seeking LTC services by case managers at a local-level single entry point. The assessment information is entered electronically into a system that calculates whether the applicant meets the state's criteria for Medicaid-funded nursing home care and HCBS waiver programs.

- Regulatory control of all LTC services and supports is also consolidated, as well as oversight of quality assurance systems.

II. What are the most significant components of a consolidated state agency?

Consolidation into one administration could include the following component parts:

- A single budget with flexibility and authority to fund an array of LTC services and supports;
- A single point of entry that does a timely and standardized assessment of financial and functional eligibility that is also used to gather hard data to manage the LTC system;
- Case management capacity to provide assistance and oversight for consumers;
- A process for resource development that meets consumer demand for services and supports;
- A fair rate setting and contracting process for providers of service;
- A structure and process for ensuring quality oversight and regulation throughout the system; and
- Integration of programs supported by Older Americans Act funds.

Three of these significant components are: 1) global budgeting—a state agency's ability to allocate LTC funds among programs and services, whether institutional or HCBS; 2) a single point of entry system, which provides information and access to all LTC services and supports and determines functional and financial eligibility for publicly funded services; and 3) an integrated system for managing the quality of LTC services and supports.

Generally, under a **global budgeting** approach (whether a state uses that specific nomenclature or not), the legislature determines the total amount of the LTC budget based on recommendations from the governor, who has based his or her budget proposal on an agency-requested amount. The agency calculates its needs according to caseloads and estimates of future demand. After the budget has been set by the legislature and approved by the governor, the agency has administrative flexibility to move funds between programs, for example, to expand HCBS programs and reduce waiting lists using the total dollars available in its LTC budget to give consumers greater choices of services.

In regard to **single point of entry systems**, these one-stop-shopping centers are increasingly being adopted in states all across the country, partially helped by federal grant funding under the Systems Change Grant program initiated in 2001. A comprehensive single point system enables local care managers to determine a person's functional eligibility for publicly funded services, assess his or her needs, and develop a care plan to deliver and monitor services. Some state agencies are developing online financial eligibility determinations, which will be available to individuals and case managers to facilitate the process and increase accessibility. Some single points of entry have streamlined procedures to expedite Medicaid eligibility decisions called **fast track** eligibility, so consumers do not have to wait as long for HCBS.

The third key component of an LTC system resulting from agency consolidation is an integrated **quality management system**. A consolidated agency is needed for the design and implementation of an integrated quality management system for LTC. While current quality assurance efforts focus on provider standards and processes, an integrated quality management system focuses on client outcomes across all LTC programs and meeting client needs across an array of services and supports. Without a person-centered focus and the responsibility for an entire array of LTC services, agencies cannot develop a cross-services integrated system. By developing quality management data systems, the agency can gather status and outcomes information on clients in all LTC programs since many consumers receive services through more than one funding source. These agencies also need regulatory control to enable the state to develop new LTC alternatives, such as assisted living, adult foster care, and other types of alternative housing.

Thus, these components facilitate access to HCBS and supports and help to provide quality services. While global budgeting and integrated quality management probably can be accomplished only in a consolidated LTC agency structure, single point of entry systems can be (and are being) developed in states without state-level consolidation.

III. What are the barriers to achieving consolidation?

Barriers to consolidation can include the difficulty of serving multiple populations with different issues and funding streams, agency turf battles, fear of big government by consumers and policymakers, and some resistance from disability groups.

- Difficulty of Serving Multiple Populations. Because the needs of persons with disabilities may vary considerably depending on their disability, developing common assessment procedures and services can be difficult.

- Agency Turf Battles. State agencies are often difficult to reorganize, particularly when reorganization can mean that some staff will lose their jobs because of the need for fewer administrative personnel or because functions change or are eliminated. One or more units may also lose budget dollars in a reorganization. In addition, the cultures of the agencies being merged may be very different.

- Various Programmatic Funding Streams and Eligibility Requirements. Federal rules differ from program to program, specifying or allowing different services. Programs have varying funding streams and different eligibility standards. This situation makes cohesion and coordination difficult.

- Resistance among Some Consumer Groups. Moving various disability populations into one agency sometimes raises fears in advocacy groups that the interests of the population they support may receive a lower priority.

- Lack of Strong Leadership.Without strong values and leadership within a consolidated structure, an agency can falter in accomplishing its mission.

(While perhaps not a barrier to consolidation, state officials point out that problems in ongoing operations can also arise when administrative responsibility lies with one agency while another agency has budget/policy responsibility.)

Officials from Washington and Minnesota described the problems that can be encountered when consolidation is underway. Charles Reed, former administrator of the Washington Aging and Disability Services Administration, said, "Long-term care system planning, development, and operation is so difficult because it must all be done at the same time. I have often joked that it is like building a 747 airplane in mid-air." Currently an independent consultant, Reed said that a "good state long-term care system must have in place an array of services for which consumers have access."

In Minnesota, although three different divisions within the Department of Human Services administer LTC services, work is coordinated through the assistant commissioner of Continuing Care, to whom they all report. The Aging and Adult Services Division and the Disability Services Division have flexibility to convert institutional funds into HCBS placements. At the local level, the Long-Term Care Consultation program assesses people of all ages for LTC services and provides information to consumers about their LTC options.

The state has not considered merging the LTC divisions into one "because of the different populations being served and where the people are being served," said Shirley York, director of the Disabilities Services Division. The goals are also different. In contrast to seniors, "the younger disabled don't spend down really; the goal is to keep them employed," she added.

IV. What were the strategies used in the five states to accomplish their consolidation goals? Who were the key actors helping the process?

Major state LTC system change generally requires two key elements:

- Leadership and vision reflecting core values on the part of top state policymakers (state agency officials, governors, and/or legislators); and

- Participation of major stakeholders, including consumers, providers, state officials, and persons with disabilities and the groups that represent them.

State officials say that leadership, philosophy, and accountability are crucial; the consolidated state agency is simply the vehicle to pull the policy and funding together. "Vision and leadership are really key, more than day-to-day management," said Jim Varpness, director of Minnesota's Aging and Adult Services Division. "People in most states administer these [programs] like they are separate programs. It [state agency structure] matters, but it doesn't guarantee" greater access to HCBS, he said. "What counts is state leadership," he added.

Also key to consolidation efforts, say state officials, is the participation of many stakeholders, from consumers to policymakers to public officials. Advancing an LTC reform agenda often begins with a task force or commission appointed by the governor with representatives from all interest groups—public and private.

Comprehensive structural change often requires public and political support, which can be engendered through these task forces or commissions and the studies and recommendations that emerge from their deliberations. Legislators often follow through on many task force recommendations by requiring the restructuring of state agencies as a first step.

V. Can a state expand HCBS without a consolidated agency? Can a state increase HCBS if it develops other system components such as a single point of entry system, fast track eligibility determinations, and comprehensive assessments and care plans that increase access?

All agency directors who were interviewed for this paper said that LTC reform *can* be accomplished without the consolidation of individual agencies. In fact, many states have been successful at shifting more funds toward HCBS. However, they all agreed that it is much more difficult and that a single agency facilitates efforts for comprehensive system reform.

Toews said that without a single agency, one would need "extraordinary interagency cooperation." Patrick Flood, commissioner of the Vermont Department of Disabilities, Aging and Independent Living, concluded, "Although you can increase access to home and community-based services without a consolidated state long-term care agency, it's 10 times harder to do unless you consolidate."

VI. How can consolidation be accomplished?

Although each state finances and delivers LTC services differently, there is great interest among state policymakers and advocates in administering and funding these services through one agency. For states that are considering a reorganization involving multiple agencies with LTC responsibilities to a single agency, the following questions could serve as a resource to assist policymakers in making informed decisions.

A Checklist for Moving to a Consolidated Long-Term Care Agency

Analyzing the Current Long-Term Care System

1. How many state agencies handle LTC services, regulation, and quality oversight?

2. What are the functions of each agency, and which populations do they serve? How many staff members does each agency have? What are the budgets for each agency and sources of funds? Can LTC funds be commingled to meet needs, or are those funds

separated in programmatic silos? How are federal requirements met for a single Medicaid or state aging agency?

3. Do these agencies share a common vision that encourages consumer information, access, choice, quality of care, and safety?

4. Does the LTC system accommodate the preferences of consumers, most of whom wish to remain in their homes and communities for as long as possible?

5. Do people with LTC needs have access to care managers for consumer information, assessment, and referrals? If so, how do they find these services in their communities? Is there a single entry point, for example, that offers these LTC services? How long does eligibility determination take? What is the nature of the appeals process?

6. Does that same single entry point agency assess and determine financial eligibility? If not, which agency does, and how long does that process take?

7. Which assessment tools do the state agencies use? Do they use different tools based on client age, disability, geographic region, or services needed to measure medical and functional needs? Are these variations warranted?

8. Are there waiting lists for HCBS?

9. Has the state established benchmark goals against which the state—and consumers—can review progress toward expanding access to HCBS, such as the percentage of total dollars spent on institutional services versus the total dollars expended on HCBS?

Redesigning Agencies and Policies to Meet Consumer Needs

1. Vision. What should be the mission and the philosophy of the new LTC agency?

2. Populations Served. Which populations should the consolidated agency serve? Is it important for the agency to serve people of all ages with physical and cognitive disabilities? Have consumers weighed in?

   The following populations could be served:

   - Older people
   - Adults with physical disabilities
   - People with mental retardation/developmental disabilities
   - Children with special health care needs

3. Functions of the Agency. What should be the functions (e.g., development of LTC policy, administration, and/or funding; LTC regulation; and quality oversight) of the consolidated agency? Will the new agency have responsibility for both LTC policy and funding? Are interagency agreements a reasonable substitution for some

functions? If so, which ones? Will the agency make it possible for the LTC system to be seamless, with coordinated funding and administration?

The various functions of a consolidated agency could include the following:

- The development and management of Medicaid LTC budget and policy
- Medicaid program administration (e.g., nursing facilities, home health, personal care, hospice, and PACE)
- Medicaid HCBS waiver program administration
- Medicaid functional and financial eligibility determinations
- Nursing home and residential care (e.g., assisted living, adult family homes, boarding homes, and group homes) regulatory oversight, survey, and certification
- Budget and policy for all in-home services
- Older Americans Act funding and policy development
- Budget and policy authority for state-funded HCBS
- Case management
- Management and oversight of Adult Protective Services
- Quality management
- Managed LTC program administration

4. The Budget. Will the consolidated agency have a single, global budget with flexibility and authority to fund an array of LTC services? Will the agency have the authority to move funds among various services, particularly from institutional to HCBS and supports?

5. Local-Level Administration. Will the consolidated agency be organized to help localities create single points of entry where consumers can easily obtain information, assessment, and services, rather than having to maneuver through a maze of county or district offices?

6. Assessment. Will the agency allow for the use of assessment tools that have common data elements to measure both functional and medical needs? Will the new agency develop fast track financial eligibility procedures to speed up approval processing, so that consumers needing immediate assistance can receive services in their homes rather than having to enter nursing homes?

7. Quality. Will the agency have an integrated quality management system that focuses on client outcomes and person-centered care across all programs? Will the agency have to develop new data systems and make other infrastructure changes to gather information and evaluate consumers and their quality of life?

Conclusion

Minnesota Department of Human Services officials say that the agency's core value is expressed in the phrase, "It's about people, not programs." That core value illustrates the central concept behind the consolidation of LTC programs and policies in one agency. Moving to a single agency allows state administrators to focus on the people needing LTC services rather than on separate silos for specific programs and specific funding streams.

This discussion paper reports on only five states' consolidated LTC agencies, but many other states are in the process of developing this kind of consolidated structure. As an example, Texas is in the midst of a major restructuring of 11 agencies under the umbrella of the Health and Human Services Commission. The functions of the 11 agencies have been merged into 4 departments. One of these departments is the Department of Aging and Disability Services, which now includes the programs from the Departments on Aging, Human Services, and Mental Health and Mental Retardation (with the exception of mental health).

Michigan provides another example of the development of state agency LTC consolidation. In June 2005, Governor Jennifer Granholm issued an executive order that creates a centralized LTC office (Office of Long-Term Care Supports and Services) within the Department of Community Health. The Office will coordinate state planning for LTC supports and services, recommend opportunities to increase these services, and improve organizational efficiency and cost-effectiveness within the state's LTC system.

In February 2005, Missouri Governor Matt Blunt signed an executive order consolidating in one agency all in-home care programs for older persons and other adults with disabilities. These programs are to be transferred to the Department of Health and Senior Services from the Department of Social Services and the Department of Elementary and Secondary Education.

Although many LTC reforms, such as single points of entry, uniform assessment, and fast track eligibility determinations can occur in states without a single consolidated agency and are being developed in many states today, a consolidated agency can help develop consistent policymaking, and focus the system on persons rather than on program providers. More importantly, this administrative structure can allow for global budgeting to ensure that funding truly follows the person, whether the person lives in a nursing home or in the community. Comprehensive system reform is much more likely to happen in states with consolidated agencies.

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State of Vermont Agency of Human Services, Department of Disabilities, Aging and Independent Living. Available at http://www.dad.state.vt.us.
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APPENDIX: STATE PROFILES

MINNESOTA

State Long-Term Care (LTC) Agencies

The Department of Human Services—an umbrella agency—houses five functional components, one of which is Continuing Care. Three Continuing Care divisions include the following:

- Aging and Adult Services Division (AASD)/Minnesota Board of Aging
- Disability Services Division
- Nursing Facility Rates and Policy Division

The directors of these divisions all report to the same assistant commissioner of Continuing Care.

The Department of Health licenses and inspects nursing facilities; other residential facilities; licensed home care providers, including home health agencies; and home care providers that serve assisted living facilities.

Populations Served

The AASD and the Minnesota Board of Aging serve persons age 60 and older.

The Disability Services Division administers services for younger people with developmental disabilities, chronic medical conditions, acquired or traumatic brain injury, and physical disabilities.

Functions of the Agencies

- The AASD administers in-home services through the Medicaid Elderly Waiver program, the Alternative Care program, and Long-Term Care Consultation. The latter program offers a variety of services to help people make decisions about LTC and find services. AASD also manages the ombudsman program, adult family services for adults age 18 and older, many of the grant programs serving people age 60 and older, and respite programs for people age 50 and older.

- The Minnesota Board on Aging administers Older Americans Act services.

- The Disability Services Division administers four Medicaid waiver programs for people under the age of 65 with LTC needs.

- The Nursing Facility Rates and Policy Division determines nursing facility reimbursement.

- Under a cooperative agreement with the Department of Human Services, the Department of Health licenses and inspects certain LTC providers such as assisted living facilities, personal care assistant services, and board and lodging.

Counties administer Medicaid waiver program services for all populations. They designate either their public health agencies or social services agencies as the lead for these programs. Minnesota is state supervised and county administered for most health and human services programs, including waiver programs and eligibility determination for Medicaid.

LTC Budgets

The AASD and the Disability Services Division are each responsible for Medicaid spending for their specific waiver programs. Each year, they calculate the numbers of people in the waiver programs and the numbers of nursing home residents. The divisions track each waiver with forecasts updated twice a year. If people want to move from nursing homes into home and community-based services (HCBS) waiver programs, the money is within each division to allow that to happen. As a result, there is no specific number of slots in the Elderly Waiver program administered by AASD. Similarly, the Disability Services Division has some flexibility within its budget to convert institutional funds into HCBS placements for its client base.

Other Initiatives

Under the Long-Term Care Consultation program, county public health nurses or social workers assess people of all ages for LTC services and provide information to consumers on their LTC options. A comprehensive database of local community resources called MinnesotaHelp.Info is available to these LTC consultants and to consumers, caregivers, and service providers. The database is sponsored by the Board of Aging and the Department of Human Services, and was created by a private organization.

The state is now working on an online financial and functional assessment tool as an add-on to MinnesotaHelp.Info that hospital discharge planners and caseworkers can use.

Interviews

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Jim Varpness, Director
Aging and Adult Services Division
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NEW MEXICO

State Long-Term Care (LTC) Agencies

The Aging and Long-Term Services (ALTS) Department was created by legislation in 2004 to consolidate all LTC functions related to older persons and adults with disabilities. Other New Mexico agencies currently with LTC responsibilities include the Department of Health and the Human Services Department (HSD). The governor created a subcabinet position to coordinate the LTC functions of the three agencies until future consolidations take place.

Populations Served

The ALTS Department serves persons age 65 and older and adults with physical disabilities. The Department of Health serves people with developmental disabilities, medically fragile persons, and persons with HIV/AIDS.

Functions of the Agencies

Phase I of the consolidation (implemented in July 2004) brought the following programs and services under the ALTS Department:

- Medicaid Aged/Disabled and Traumatic Brain Injury waiver programs
- Medicaid Personal Care optional services
- Program for All-Inclusive Care for the Elderly (PACE)
- State-funded HCBS

While ALTS has oversight of these programs and operational responsibility for a number of LTC programs, policy and budget control still lies largely with HSD in many respects. In Phase II of the consolidation (implemented in July 2005), ALTS assumed responsibility for Adult Protective Services. In Phase III, the secretary of the ALTS Department will recommend to the legislature whether other disability populations and/or functions should be moved to the agency.

As of June 2005, however, the Department of Health continued to manage the Medicaid waiver programs for persons with developmental disabilities, medically fragile persons, and persons with HIV/AIDS, and is also responsible for operation of state-run institutions.

HSD is the Medicaid agency whose local offices determine Medicaid financial eligibility. HSD also has control/responsibility over the level-of-care determination process since it is the agency that contracts with outside entities for utilization review.

LTC Budget

The ALTS Department has oversight of the programs implemented in Phases I and II, but HSD manages the budget for those programs.

State Legislation

Enacted during the 2004 legislative session, House Bill 34, Chapter 23, creates a single, unified department to exercise all functions formerly administered by the state agency on aging and those functions that relate to aging, adults with disabilities, or LTC services that had been housed in the Department of Health, the Human Services Department, and the Children, Youth and Families Department. The goal is to "focus on creation of a seamless, comprehensive, efficient and cost-effective home and community-based long-term care system."

House Bill 34 also requires the ALTS Department to provide the legislature with a "comprehensive plan" by November 1, 2005, on providing LTC and related services for *all populations,* including any recommendations the Department might have for further transfers from other departments. As of the end of 2005, the document was being described as more of a "state of the state" report rather than a plan. Limited resources have hampered the development of a comprehensive plan.

Other Initiatives

Self-Direction: The state has been working since 2000 on an interagency Medicaid self-directed waiver program called *Mi Via* (the departments involved are ALTS, Health, and Human Services). When fully implemented, the program will offer eligible participants options for controlling and directing their LTC services and the use of their Medicaid funds using person-centered planning and individual budgeting. Participants in the state's four Medicaid HCBS waiver programs, Medicaid residents of nursing homes and intermediate care facilities for the mentally retarded, and participants in traumatic brain injury and mental illness programs will all be eligible to choose this new program.

Single Point of Entry: ALTS is developing an Aging and Disability Resource Center (ADRC) and working with other departments to access additional services, such as transportation and housing, for consumers. The ADRC uses a Medicaid database to access its clients and is working toward developing the capability to determine financial eligibility. The next step is to create a Web site database of community resources for senior centers, hospital discharge planners, and others.

Interview

Deborah Armstrong, Secretary
Aging and Long-Term Services Department
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OREGON

Consolidated State Long-Term Care (LTC) Agency

The Seniors and People with Disabilities Division within the Department of Human Services

Populations Served

- Seniors
- People with physical disabilities
- People with developmental disabilities

Functions of the Agency

- Medicaid LTC budget and policy
- Medicaid waivers
- Medicaid functional and financial eligibility
- Nursing home and residential care (including assisted living, adult family homes, boarding homes, group homes, etc.) survey and certification
- Older Americans Act policy and budget

The administrator of the Seniors and People with Disabilities Division and the administrator of the Oregon Health Plan are co-directors of Medicaid.

LTC Budget

The legislature gives the division a "global budget" appropriation each biennium. The division has budgetary authority for *both* institutional services and HCBS. This budgeting authority allows agency officials to manage the LTC budget as one allocation. Officials can determine the most appropriate care setting for individual consumers, without being constrained by separate budget lines for HCBS and institutional care.

The legislature adopts a single budgetary line item for LTC by adopting certain assumptions about the proportion of persons who will receive services in various settings. Agency staff closely monitor program data in terms of participants and costs. Thus, the division can accurately project funds needed for each level of care.

State Legislation

The state enacted legislation in 1981 to create a consolidated division. (The following website covers the Oregon Revised Statutes dealing with the policy on aging and disability, and details the role of the consolidated agency in design and delivery of services: http://www.paperadvantage.org/ORS/410.html.)

Other Initiatives

Over the last 25 years, Oregon has gradually shifted its public LTC funding from institutions (such as nursing homes) to HCBS. In FY 2004, the state allocated 70.5 percent of its total Medicaid LTC dollars to community-based services and only 29.5 percent to institutional care. Almost 34,000 persons received HCBS under the Medicaid waiver program, compared with about 5,100 publicly funded nursing home beds (projected to decline to about 4,700 in next two years). State officials credit a number of organizational moves with helping to contribute to this result.

- The state has integrated all Medicaid community and institutional LTC programs at the local level, through area agencies on aging and county offices. Assessment, eligibility determination, and case coordination for Older Americans Act services, Medicaid, and even food stamps are handled by the same county offices.

- A standard automated assessment is administered by case managers at a local-level single entry point to all individuals seeking LTC services. The assessment information is entered electronically into a database that calculates whether the applicant meets the state's nursing facility level-of-care criteria.

- Oregon offers LTC applicants a wide range of options for community care, including the opportunity to employ and manage providers whom they select.

Interview

James Toews, Assistant Director
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VERMONT

Consolidated State Long-Term Care (LTC) Agency

Department of Disabilities, Aging and Independent Living (DAIL) within the Agency of Human Services

Populations Served

- Seniors
- People with physical disabilities (including some children with disabilities)
- People with developmental disabilities

Functions of the Agency

- Medicaid waivers
- Medicaid functional eligibility
- Nursing home and residential care (including assisted living, adult family homes, boarding homes, group homes, etc.) survey, and certification
- Older Americans Act policy, programs, and funding
- Case management
- Quality and policy for in-home services

LTC Budget

The Office of Vermont Health Access (OVHA) has overall budget responsibility for Medicaid LTC services, while the Department of Children and Families (DCF) has responsibility for financial eligibility. However, DAIL meets monthly with OVHA and DCF staff to coordinate efforts around LTC funding and eligibility, and the Long Term Care Choices for Care (LTCCC) staff sit in the same offices with the DCF eligibility staff to facilitate communication. (LTCCC is a new Medicaid demonstration program that gives consumers greater LTC choices as described below.) The department oversees Medicaid nursing home and HCBS funds "for all practical purposes," said DAIL Commissioner Patrick Flood, but actual authority resides with the Medicaid agency.

Financial management of both nursing home and HCBS programs are consolidated in the department, with DAIL responsible for developing a spending plan. Monthly expenditures are tracked by program, with estimates made of the savings that occur each year. The department manages the budget amount appropriated each year by controlling the number of persons served at any one time and monitoring actual cash expenses on a monthly basis.

If, toward the end of the year, money is left over in the nursing home budget, DAIL can use those funds for HCBS.

State Legislation

In the FY 2003 Appropriations Act, the General Assembly instructed the Agency of Human Services to recommend a comprehensive plan for reorganization of the agency's operations. The result was the creation of DAIL. Previous legislation in 1996, Act 160, had laid the groundwork for LTC reform efforts in the state.

Other Initiatives

In spring 2005, Vermont received federal approval for a demonstration waiver to combine Medicaid HCBS waiver funds with the state's nursing home appropriation in a "global budget" in a program called "Choices for Care." The approval caps three years of work that began with a planning process involving providers, advocates, and consumers. The plan breaks the current link between nursing home functional eligibility and eligibility for HCBS. Medicaid policy stipulates that only those persons who meet nursing home eligibility criteria can be deemed eligible for HCBS waiver services. Under the Vermont plan, the state raises its nursing facility level of care criteria to a higher level. However, the state will continue to make HCBS available to people who meet the *current* nursing facility level of care, as well as people at risk for nursing facility placement who do not yet meet those criteria.

- Eligible elderly persons or persons with disabilities will have the option of receiving either Medicaid-covered HCBS or care in a nursing home. Persons choosing HCBS will not have to wait for a slot to open up in the Medicaid waiver program, as is currently the case.

- The state will establish a priority system for eligibility: highest need, high need, and moderate need. The **highest-need** group, who must meet the state's Medicaid financial and functional eligibility criteria, will be entitled to either nursing home care or HCBS. The **high-needs** group will not be legally entitled to long-term services and supports, but these individuals will be served to the extent that funds are available. The **moderate-needs** group will consist of persons who do not meet nursing home or HCBS waiver functional eligibility criteria, but are believed to be at risk for institutionalization based on their assessed care needs.

- The type and amount of service will depend on the assessed strengths and needs of each individual.

Interview

Patrick Flood, Commissioner
Department of Disabilies, Aging and Independent Living
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WASHINGTON

Consolidated State Long-Term Care (LTC) Agency

Aging and Disability Services Administration (ADSA) within the Department of Social and Health Services (DSHS)

Populations Served

- Seniors
- People with physical disabilities
- People with developmental disabilities

Functions of the Agency

- Medicaid LTC budget and policy
- Medicaid waivers
- Medicaid functional and financial eligibility
- Nursing home and residential care (including assisted living, adult family homes, boarding homes, group homes, etc.) survey, and certification
- Older Americans Act funding and policy
- Case management
- Budget and policy for in-home services

There are two LTC functions that ADSA does not handle: licensure of home care agencies (the responsibility of the Department of Health) and home care worker recruitment and retention activities (coordinated by the Home Care Quality Authority).

LTC Budget

A global budget for the ADSA allows the agency to transfer money among line items. That means that ADSA can move money between nursing homes and HCBS.

State Legislation

The agency carried out its consolidation through administrative action, not through state legislation. Legislation was not needed because all the different LTC divisions were already under the Department of Social and Health Services (DSHS) umbrella before the consolidation. The only exception was the transfer of boarding home licensing from the Department of Health to DSHS. The Governor did want to move the function administratively, but a statute change was required.

Other Initiatives

- Between FY 1997 and FY 2002, the average number of Medicaid-funded nursing home residents per month declined by more than 1,800 (12 percent), while the average HCBS caseload increased by 9,000 (39 percent).

- The state's fast track financial eligibility determination process allows local ADSA staff to authorize HCBS before the completion of a formal official determination.

- In short, the consolidation has led to increased HCBS options, no waiting lists, and a reduction in the nursing home population every biennium since the FY 1995-96 budget.

Interviews

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