

**State Long-Term Care Systems:
Organizing for Rebalancing**

**Topics in Rebalancing State Long-Term Care Systems,
Topic Paper No. 2**

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Table of Contents

Preface.....	iii
Executive Summary	iv
Introduction.....	1
Relevance of Topic for Rebalancing	1
Focus and Organizing Questions	3
Approach.....	4
Comparisons of the Structure of 8 State LTC Systems	4
Demographic Variations	4
Variations in Number of LTC Programs Operated.....	5
Structural Integration in the 8 States	6
Integration of Functions	7
Budget allocation.	7
Planning and policy-making	8
Operations	8
Quality Assurance or Monitoring	10
Integration of Programs	10
Integration of programs within Medicaid	10
Integration of State-funded or State-operated federal programs with Medicaid programs	11
Population-Specific Integration	11
Centralization versus Decentralization	12
State-by-State Discussion	13
Arkansas.....	14
Florida	14
Minnesota.....	15
New Mexico.....	15
Pennsylvania	15
Texas	16
Vermont	16
Washington	17
Conclusions.....	17

Table of Appendix

Appendix: Organizational Charts	20
Figure A1. Arkansas Department of Human Services in August 2006	21
Figure A2. Arkansas Division of Aging and Adult Services, July 2005	22
Figure A3. Organizations Involved with LTC in Florida, August 2005	23
Figure A4. Florida Agency for Health Care Administration, August 2005	24
Figure A5. Minnesota Governor's Health Care Cabinet, July 2005	25
Figure A6. Minnesota Department of Human Services, August 2005	26
Figure A7. New Mexico Governmental Structures for Long Term Care, August 2005	27
Figure A8. New Mexico Aging and Long-Term Services Department, June 2006	28

Figure A9. Pennsylvania Department of Public Welfare, August 2005	29
Figure A10. Pennsylvania Department of Aging, August 2005	30
Figure A11. Texas Health and Human Services Commission (HHSC), August 2005	31
Figure A12. Texas Department of Aging and Disability Services (DADS), August 2005 ...	32
Figure A13. Vermont Agency for Human Services, 2005	33
Figure A14. Vermont Department of Disability, Aging, and Independent Living, 2005	34
Figure A15. Washington Department of Social and Health Services (DSHS) and	35

List of Tables

Table 1: Relevant Variations in the 8 States	5
Table 2: Home and Community-based Programs Operated by Each State	6
Table 3: Ratings of Integration and Centralization in LTC Organization	13

Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 states to explore the various management techniques and programmatic features that states have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. In October 2004, CMS accordingly commissioned this study to examine that topic. The states of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year study of rebalancing. For the study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its state plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the study include state-specific case studies that look qualitatively and quantitatively at each state’s management approaches to rebalance their long-term care systems; the first set of those reports that review each state’s experiences up to July 2005, and a Highlight Report summarizing all 8 States have already been released.¹ Updates of the state-specific case studies summarizing changes up to July 2006 will appear in the fall of 2006 and more extensive follow-up is planned for release in the fall of 2007.

The other products for the study are comprised of a series of papers, called *Topics in Rebalancing*. Each topic paper highlights an issue of importance in state rebalancing efforts, and each draws on experiences in some or all of the 8 States in the rebalancing study to illustrate the issue.

For this particular Topic Paper, *State Long-Term Care Systems: Organizing for Rebalancing*, we drew on our original state case studies and a wide range of interviews with state officials and representatives of advocacy groups. We also reviewed documents and web materials, including rosters and minutes of various advisory groups. We thank everyone who took the time to share their experiences and impressions. We also thank our CMS project officer from CMS, Dina Elani, for her continual assistance. The findings and conclusions in the paper are those of the authors and do not necessarily reflect those of CMS, its staff, or any State officials. We hope that this topic paper will stimulate discussion, and we welcome any comments or reactions.

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¹ The Executive Summary and the 8 abbreviated case studies are available on the CMS website at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage, as well as on <http://www.hcba.org> and the Study director’s website at <http://www.hsr.umn.edu/LTCResourceCenter/>. Longer State reports can be found at the last two sites.

Executive Summary

This Topic Paper compares approaches to organizing long-term care (LTC) and long-term support programs at the State level in 8 states, with emphasis on two organizational features: integration and centralization.

Integration (versus fragmentation) is defined in 3 ways:

- 1) integration of key functions for long-term care, including: budget allocation; planning and policy-making; operations (which includes assessment of financial eligibility, assessment of functional eligibility, care and service planning, implementation of plans, contracting for and reimbursing service providers, licensing or certifying service providers, and interacting with field offices for these operational functions) and quality assurance or monitoring (including oversight and protective functions).
- 2) integration of programs within Medicaid, including institutional and home and community based programs, and integration of Medicaid long-term care support programs with other state-operated or state-funded programs that are not part of Medicaid;
- 3) integration of functions and programs for all long-term care consumers regardless of age or type of disability.

In theory, a State agency can be structured in a highly integrated way across functions and programs (including integration of management of institutional and HCBS programs) for particular target populations, while maintaining separate organizations for consumers from other target groups. Some states report an advantage, however, in moving the management of LTC for multiple populations into fewer authorities, or even a single authority; such integration achieves cross-fertilization across age and disability groups that may assist rebalancing goals. Since 2000, the trend to integrate through organizational merger and pinpointing of responsibility is illustrated by Texas, Vermont, and Washington. Integration through inter-agency collaboration is illustrated in New Mexico and Arkansas. At times, however, a separate department has been created for a particular population, as was the case with the creation of the Agency for Persons with Disability in Florida, which has achieved considerable success in expanding choice and community care for consumers with developmental disability.

The highest level of integration is exemplified in Washington, where all LTC functions and programs for all populations (with the exception of an AIDS/HIV waiver) are unified in a single accountable department within an umbrella agency. Texas and Vermont have highly integrated functions and programs as well, but in neither of those States does the entity responsible for LTC also perform financial eligibility for Medicaid.

Centralization (versus decentralization) refers to the extent to which discretion and decision-making occurs at State versus local levels. Markers of centralization include uniform assessment protocol(s) and procedure; use of State personnel in local areas for assessment and care-planning functions; number of entry points to LTC at the local level, State monitoring of local operations, statewide training functions, State ability to re-budget resources across localities, and local understanding of and sharing of State programmatic goals.

This Paper concludes with the hypotheses that integration will be positively associated with rebalancing success, and urges further work to operationally define elements of integration and examine their relative importance. Rebalancing hypothetically will be enhanced by some centralization, but optimal amounts of local discretion have not been well established.

State Long-Term Care Systems: Organizing for Rebalancing

Introduction

Relevance of Topic for Rebalancing

The responsibility for administering publicly funded long-term support and long-term care (LTC) programs, and for the licensing, quality control, and protection of clientele for all LTC programs regardless of funding, rests with the fifty states and the District of Columbia. Given the wide array of disabilities and conditions engendering the need for LTC and the variety of functions involved, a large number of State departments may be involved in the enterprise. To the extent that LTC programs are funded under Medicaid, the State's Medicaid agency, located in various places in State governments, must be involved. Other State departments or agencies typically involved in planning, administering, or overseeing LTC programs can include: Aging; Mental Retardation (perhaps called Developmental Disability or just Disability); Mental Health; Health; Families and Children (formerly more often called Child Welfare and/or Social Services); Education; Veterans Affairs, Vocational Rehabilitation; and Budget. (Some States combine some of the departments on this list, which, moreover, is not an exhaustive list of State departments and agencies directly engaged in LTC).

In the last decades, many States have reorganized their health and human services in general, and their long-term care programs in particular. Often these reorganizations are designed to achieve general efficiencies or achieve purposes unrelated to LTC. Regarding LTC, one tendency seems to be towards integration of many functions and responsibilities

State governmental structures for long-term care can assist or impede implementation of Rebalancing goals. A tendency towards integration of governmental organizations relevant to LTC has been observed over several decades. The opposite tendency to create separate high-level governmental entities to focus on specific populations of clientele has also been observed.

related to LTC, including budget authority, in a single department for aging and disability, which is either a cabinet level department or a major division within an umbrella agenda for human services or for both health and human services.² The opposite tendency is also found: the breaking off of functions or populations into separate high-level agencies, including for example, cabinet-level agencies for aging or for developmental disability. States engaged in rebalancing LTC have a keen interest in the implications of various structural arrangements for their likely success in the rebalancing efforts. Reorganization of State governmental agencies carries costs in disrupted relationships and communication channels as well as financial costs for aligning information systems, office space, policies, and procedures, and cannot be undertaken lightly.

Rebalancing, in this project, refers to shifting the balance of State Medicaid utilization and expenditures for long-term supports towards less institutional service and more community services. States undertake rebalancing in the context of their responsibility for the full gamut of long-term care and long-term support services. Succinctly stated, the overall LTC goal for State

² See Fox-Grage, W, Coleman B, & Milne, D (2006). Pulling Together: Administrative and Budget Consolidation of State Long-Term Care Services. Washington DC : AARP.

organizations engaged in rebalancing is: *to provide good quality long-term care services to clients that are received quickly and in forms and at locations that consumers prefer.*³

To meet this goal, the State must be able to deliver the full array of home and community-based services (HCBS) and institutional services available across the entire State, have a mechanism for getting information about services to the consumer, be able to establish the consumer's eligibility for services, and effectuate care plans, and be able to adjust its

Alignment of budgetary, programmatic, and oversight responsibility arguably helps States meet overall rebalancing goals: i.e. good quality LTC services provided quickly and in forms and locations that accord with consumer preferences.

offerings to meet changing demands as consumers experience and increasingly choose HCBS services. To the consumer, the minutia of how money gets allocated to various State and waiver programs and what agency administers these programs at a State level may well be irrelevant. But to State LTC authorities, the details of aligning the budget with program responsibilities in accordance with consumer preferences, and aligning the licensing and control of supply of services with program operations may make the difference in achieving the overall goal for long-term care.

States in the process of rebalancing have been challenged to design administrative systems that achieve the following:

- accountability for achieving high quality LTC;
- accountability for developing a system that accords with consumer preference at the point of service need;
- clarity of commitment within the ranks of all relevant State personnel to a vision about LTC in the State; ability to plan strategically, set policy, and communicate an overall strategy to the legislature;
- ability to react promptly and effectively to correct problems;
- ability to allocate resources to meet LTC goals;
- ability to collaborate effectively with other relevant State organizations responsible for programs that link with LTC, such as health, mental health, housing, employment, and education.

Functions such as planning, budget allocation, operations, and quality assurance across the full range of community and institutional LTC programs could be organized in different agencies in an integrated fashion for specific populations. Conversely, a State could integrate programs for all or most populations receiving LTC into a single administrative entity. Some long-term care leaders hold it as a strong article of faith that the best organized state long-term care systems

³ This definition of the LTC product was generated by Charles Reed, Dann Milne, and Douglas Stone, formerly State LTC officials and leaders in Washington, Colorado, and Oregon respectively during a meeting in Pittsburg, PA, October 16, 2006.

are those that have most, if not all, the component parts of the long-term care system in one place.⁴

“The best organized state long-term care systems are those that have most, if not all, the component parts of the long-term care system in one place.” Charles Reed, October 30, 2006.

States also vary in the degree to which their LTC programs (either as a whole or as organized for specific target populations) are centralized with uniform policies at the State level that are implemented uniformly and with a minimum amount of discretion at local levels. The degree of centralization is dependent on a State’s size, its history of relationships between State and local governments, and its county structure.

Focus and Organizing Questions

This Topic Paper addresses whether certain organizational characteristics of state LTC systems are likely to be associated with greater rebalancing towards community care. The specific questions addressed are:

- Should state organizations that manage institutional and community based care be integrated into a single State entity? Are the interests of a particular target population better maintained by a visible, cabinet-level agency with a mandate to work on its behalf, or by a single agency responsible for LTC programs for all populations? Does this depend on the historical accomplishments of the specific group at the time reorganization is considered?
- How can budgetary responsibility be best aligned with LTC program responsibilities?
- How can a State organize to minimize delays in processing eligibility for State-subsidized LTC? Should the Medicaid agency, for example, delegate responsibility for functional and financial eligibility for Medicaid LTC programs (including waiver programs) so that the initial assessments of functioning and financial responsibility are integrated into an organization bearing overall accountability for LTC?
- What State level structures and processes best promote communication, cross-fertilization, and articulation of services between long-term supports and other relevant service sectors, such as acute care, housing, mental health, education, employment, and income supports?
- To what extent should policies and programmatic decisions on matters such as eligibility, service options, licensing, and rate-setting be made at the State level as opposed to being made at local discretion?

These questions cannot be answered definitively within the context of available information about the 8 States in the rebalancing research project. Moreover, it is infeasible for all States to

⁴ Comment of Charles Reed, AARP National Policy Committee and formerly director of the Aging and Disability Services Administration, State of Washington., Personal Communication, October 30, 2006.

adopt a single organizational form, even if such an optimal form could be identified. But through a close look at organizations and the experiences of the States in the Rebalancing Study within the constraints of the information we had available, this Topic Paper suggests approaches and pinpoints issues related to integration and centralization, as well as cross-state and cross-disability equity that are relevant to achieving rebalancing within the structure of each State.

Approach

This Topic Paper builds on detailed case studies conducted in 8 states for the period until July 2005 and updated information through August 2006 to compare the structures of state

This Topic Paper examines how State governments are organized for managing LTC in a rebalancing system along two dimensions: integration versus fragmentation and centralization versus decentralization.

LTC systems, and consider the implications of these structures for the goal of rebalancing. The paper draws on organizational theory, LTC literature, and opinion of experts in State LTC policy to define two dimensions of State organization potentially relevant to achieving the goals of a rebalanced LTC system: 1) integration, or the extent to which functions, programs, and populations for long-term care in a State are combined or articulated within State organizations; and 2) centralization, or the extent to which LTC decisions are made at the state or local levels. Making broad judgments, we characterize each State on these 2 dimensions. In the discussion, we take into account considerable inter-state variation that would also be relevant to the organization structures States adopt.

Comparisons of the Structure of 8 State LTC Systems

Demographic Variations

The 8 States collaborating in the Rebalancing Research differ markedly in geographic size, population, per capita income, poverty rates, age distribution, and prevalence of disability. These factors impact demand on a state's LTC system and affect the State's ability to respond and the way a State is organized to deliver services. The 8 States also vary in the general organization of their Executive and Legislative branches, their county and municipal structures, and more amorphous attributes such as the prevailing political climate (see Table 1). All these variations undoubtedly can affect both State organizational patterns and rebalancing results. Regardless of geography, demography, or political climate, however, the LTC authorities in all 8 States have expressed a firm commitment to the goal of rebalancing LTC programs, and the Governors and State Legislatures in all 8 States have affirmed and supported that goal.

The States also vary in the number of programs that they operate for long-term

The sheer number of discrete LTC programs operated by a State increases administrative complexity, and requires thought about mechanisms to ensure smooth functioning to achieve overall rebalancing goals.

care. Nationally, variation in how States use their Medicaid State Plans, and the separate services included in the plans has always been high. As Medicaid waiver programs evolved after their initial implementation in 1982, opportunities arose to create separate waivers to meet particular needs, leading to different patterns by State in the number of waivers and the range of

services included in a waiver. States also developed special State-funded programs for particular services. Similarly, States vary in the number of demonstration waivers under 1115 authority that include long-term care. The reasons for any State's particular pattern may relate to political issues and historical circumstances that rendered approval for new versus modified waivers more or less difficult. Some States have opted, for example, to use a separate waiver for assisted living, whereas others include services to consumers in assisted living settings within their Aging and Disability waivers. An 1115 waiver may signal an innovative stance within the State, and suggests that the State has seized an opportunity to try a new approach. Similarly, successful grant acquisition typically involves establishing a mechanism to review and manage the grant activity, and adds to the complexity of the State's programs.

Table 1: Relevant Variations in the 8 States

State	Size in square miles ¹ (US rank)	Population 2005 ² (US rank)	Per capita Income 1999 ³	% Elderly in population 2005 ⁴ (US rank)	% disabled in population 2005 ⁴ (US rank)
AR	53,179 (29) Medium ⁵	2,779,154 (32) Medium	\$16,904 (49) Low	13.5% (10) High	28.8% (3) High
FL	65,755 (22) Medium	17,789,864 (4) Large	\$21,557 (19) Medium	16.6% (1) High	19.4% (27) Medium
MN	86,939 (12) Large	5,132,799 (21) Medium	\$23,198 (11) High	11.6% (38) Low	16.2% (44) Low
NM	121,589 (5) Large	1,928,384 (36) Small	\$17,261 (46) Low	12.1% (30) Medium	22.2% (13) High
PA	46,055 (33) Medium	12,429,616 (6) Large	\$20,880 (25) Medium	14.6% (3) High	20.6% (23) Medium
TX	268,581 (2) Large	22,859,968 (2) Large	\$19,617 (33) Medium	9.6% (48) Low	18.9 (31) Medium
VT	9,614 (45) Small	623,050 (49) Small	\$20,625 (26) Medium	12.8% (17) High	22.4% (12) High
WA	71,300 (18) Medium	6,287,759 (14) Large	\$22,973 (13) High	11.1% (45) Low	20.8% (22) Medium
US	3,794,083	296,410,404	\$21,587	12.1%	19.4%

1. U.S. Census Bureau (2005) Density Using Land Area For States, Counties, Metropolitan Areas, and Places: 2000 At: <http://www.census.gov/population/www/censusdata/density.html> (accessed 10/3/06) (last updated August 15, 2006).

2. U.S. Census Bureau Population Division (2005) Table 1: Annual Population Estimates: 2005. At: <http://www.census.gov/popest/states/NST-ann-est.html> (accessed 10/3/06) (last updated December 21, 2005).

3. U.S. Census Bureau (2005a) State and Local Government Finances: 1999. At: <http://www.census.gov/govs/www/estimate.html> (accessed 10/3/06) (last updated May 31, 2006).

4. U.S. Census Bureau American Community Survey (2005). Fact Sheets. At: http://factfinder.census.gov/home/saff/main.html?_lang=en (accessed 10/3/06)

5. The ratings of high, medium, and low are simply based on whether the State falls, respectively, in the top, middle, or bottom third of all States on the parameter in question.

Variations in Number of LTC Programs Operated

The more discrete programs in long-term care that the State administers, the more it is challenged to maintain articulation among the programs and to present a seamless face to consumers who are endeavoring to learn about the programs and to arrange for long-term care that meets their needs and preferences. When the programs include capitation to managed care organizations, the State has an additional onus to maintain overall accountability for these decentralized programs. Each State operates a Medicaid nursing home program, and Table 2

illustrates the variation among the 8 States in terms of the number of HCBS programs operated through waivers, Medicaid State Plan LTC services, and separately identified state-funded or State-operated LTC programs outside of Medicaid as of July 2005.⁵ The range of 24 and 22 in Texas and Pennsylvania, respectively, to 10 in Minnesota and New Mexico does not present the entire picture of complexity because several States also operate long-term care in programs with 1115 demonstration waivers, either as solely long-term care programs or as programs with acute care and LTC. For example, both Arkansas and Florida operate Cash and Counseling programs under the original 1115 waivers granted during the evaluation period. Minnesota operates two capitated programs, Minnesota Senior Health Options and Minnesota Disability Options, which cover both acute care and LTC on a capitated basis. Florida and Texas both operate several programs with managed LTC, and the closely watched Vermont program, Community Choices, was launched in October 2006 under an 1115 waiver.

Table 2: Home and Community-based Programs Operated by Each State

	HCBS Waivers	Medicaid HCBS State Plan	State HCBS programs	PACE Sites	Total
AR	6	5	0	0	11
FL	12	3	2	1	18
MN	5	4	1	0	10
NM	4	3	2	1	10
PA	11	2	3	6 ¹	22
TX	8	5	9	2	24
VT	5	6	3	0 ²	14
WA	5	4	2	1	12

¹ Pennsylvania has 4 full PACE sites and 2 pre-PACE sites; the latter has capitated Medicaid LTC services only but have not yet integrated Medicare care into the program.

² Vermont has a PACE project in the planning stages.

Structural Integration in the 8 States

Studies of structure in acute healthcare delivery settings typically compare organizations using 3 dimensions: integration, centralization, and specialization.⁶ Here we have applied the first two constructs to the systems States put in place for rebalancing. Our thesis is that success requires States to develop locally appropriate approaches to 2 common tasks, i.e., (1) integration

⁵ The Sources for these counts include the Case Studies performed in the Rebalancing Study, cited in Reference 1; internal records of the Center for Personal Assistant Services at UC San Francisco, for which see Kitchener, M, Ng, T & Harrington C (2006). *Medicaid Home and Community Based Services Data 1999-2003*. San Francisco, University of California San Francisco; Kaiser Family Foundation annual summaries of Medicaid programs; and information on the website of the National PACE Association. We may have undercounted some programs, especially for children and for people with mental health problems or developmental disabilities. Nonetheless, the table gives some idea of the relative complexity of LTC delivery in each State.

⁶ These domains have largely been explored in studies of the operation of health care systems and their effectiveness in achieving specific outcomes, such as access or cost control. See Bazzoli, G, Shortell, S, Dubbs, N, Chan, C & Kralovec, P (1999), A Taxonomy of Health Networks and Systems: Bringing Order Out of Chaos. *Health Services Research* 33 (6), 1683-1717. Applying these constructs to State structures for achieving high quality rebalanced LTC is paving new ground and we found little relevant literature for guidance.

of the functions and programs related to long-term care to pinpoint accountability, enhance commitment to common goals, permit flexible use of resources to achieve those goals, ensure effective information flows, and achieve a workable balance between the sometimes conflicting pressures to combine programs for administrative efficiency and serve the needs of multiple target groups; and (2) achievement of an appropriate balance between central and local decisions making (centralization).⁷

Integration refers to the approaches used by State LTC systems for assigning accountability and for coordinating activity and information flows among functions and programs. One approach to integration is to combine all functions and programs in a single organization.

Another is to devise highly interactive methods of communication and joint problem solving among

Three ways for State LTC structures to be integrated: integration of key LTC functions; integration of services and programs; and integration across consumer populations.

multiple entities—perhaps even Cabinet level agencies. Even among highly centralized state LTC systems with a single umbrella entity responsible for LTC, further integrative efforts are required. A multitude of approaches exist to achieve the necessary communication and collaboration. This topic Paper distinguishes 3 kinds of integration for LTC: integration of key functions, integration of services and programs; and integration across consumer populations who receive LTC.

Integration of Functions

The following functions have been identified as important to long-term care: budget allocation, planning and policy-making, operations, and quality assurance or monitoring.

Budget allocation. Budgets for LTC are generally allocated by State legislatures and divided into at least

some
general
segments:
e.g. nursing
home
budget,

Planning and budgetary control are pivotal functions for State lead agencies in LTC. Especially when a change in direction is underway, as in rebalancing, some experts argue that the planning and forecasting process and the budgetary accountability should be in the hands of the same entity that operates the programs. .

community care budget for seniors and adults with disabilities. Some States may allocate budgets even more finely to a variety of program silos. Within such budget allocations, however, some States authorize a single agency to work with all or most of these budgets, and even allow the head of that organization the administrative flexibility to reallocate up to a certain proportion among budgetary categories without requesting prior permission. Washington exemplifies a State with budgetary responsibility and control for LTC integrated into a single administrative entity, the Aging and Disability Services Administration (ADSA). Moreover, the budget

⁷ The third organizational construct, specialization, may also be relevant to State organization for LTC. The more programs an organization undertakes to operate, the more complexities the organization encounters. States typically operate numerous LTC programs funded by Medicaid State Plans, Medicaid waivers, state-funds, and grant funds, sometimes developing them in response to opportunity. They are then challenged to operate the programs in a way that minimizes confusion and disruption to consumers at the point of service use. We did not include this construct in our analysis because of uncertainty about how to properly measure specialization in this context.

amounts awarded by the legislature are tied to a forecasting process whereby the ADSA provides the original estimates of need to the legislature.

Planning and policy-making. Although closely linked to budgeting, planning and policy making are separate endeavors through which a State thinks strategically about its LTC programs, and plans for areas of growth and development. Planning efforts are used to reexamine priorities and goals, set operational targets, reconsider the adequacy of the array of services, and design innovative programs for testing. Included in planning is the process by which a State determines, for example, which of the many federal and private grant opportunities it will pursue; such grant opportunities have been a major vehicle for State innovations in long-term care.

Several of the States (e.g., Washington, Texas, Vermont) in this study have integrated their LTC planning function with operations in a single agency for all target populations (the ADSA, the Division of Aging and Disability Services [DADS], and the Division of Aging and Independent Living [DAIL], respectively); all 3 of these integrated agencies are found within umbrella organizations. In other States, various coordinating mechanisms are in place to plan LTC across target populations for which different organizations have responsibility (in New Mexico, collaborating cabinet level agencies; in Arkansas, collaborating units of an umbrella agency; and in Pennsylvania, a planning function in the Governor's office and, since October of 2005, a super-ordinate Long Term Living Council of cabinet level officials). However, in the examples of Arkansas, Pennsylvania, and New Mexico, operations are vested in multiple other organizations.

Operations. Key operational functions include: financial eligibility assessment, functional eligibility assessment, planning care and services, arranging care and services, and licensing or registering providers. Because the Medicaid program is a major vehicle for publicly financed LTC, eligibility for

Key operational functions include: financial eligibility assessment, functional eligibility assessment, planning care and services, arranging care and services, licensing or registering providers of services, payment and reimbursement, and managing state-wide field operations.

Medicaid is a key component of operations. In Washington, financial eligibility for Medicaid LTC is vested in the ADSA. In the 7 other States, financial eligibility determination is separated from the other functions, but in various ways the States are trying to make eligibility determinations more efficient and timely through inter-organizational cooperation, state-wide computer-assisted methods, and/or collocation of eligibility and program officials at the local level. Assessment of functioning and unmet needs is used to determine nursing-home-level plan regardless of whether he or she meets the nursing-home threshold. Once care levels and functional needs are determined, care or service planning, and service authorization and implementation must proceed. At the State level, some officials are typically assigned the responsibility of interacting with a network of local service entry points. All States have some responsibility for setting in motion, working with, and overseeing field operations. The more integrated the State LTC system, the more the agency responsible for budget and planning, on the one hand, and for monitoring and quality assurance on the other, will have accountability for field operations.

Officials and former officials in the State of Washington argue strongly for the advantages of ceding authority for Medicaid

Some argue that financial eligibility for Medicaid LTC and functional eligibility for all LTC programs should be entrusted to the agency that is responsible for operations so as not to incur delays because of competing priorities and to avoid creating a bias towards institutional placement.

financial eligibility assessments to the same entity responsible for LTC. Other States report varied experiences. Vermont's director of the Department of Disability, Aging and Independent Living expressed satisfaction with retaining the financial eligibility function in the Department of Children and Families. In New Mexico, the three relevant Cabinet secretaries for Aging and Long-Term Services, Health, and Human Services have collaboratively developed a procedure for both financial and functional eligibility assessment that is subcontracted to a Health Maintenance Organization and administered by home health nursing agencies in the vast State. Arkansas and Pennsylvania are both in the midst of initiatives to try to simplify and speed up eligibility for services.

Another sign of integration is the placement of the network of aging services with the State Unit on Aging, which by federal statute manages and allocates funds to that aging network. In Texas, Vermont, and Washington, the Aging Network is administered within a highly integrated organization that manages LTC services for seniors and for other populations. In Arkansas, the aging network is situated within an Aging and Adult Services Division that administers an array of Medicaid waiver programs and undertakes planning and innovation for seniors and persons with physical disabilities, but not for persons with Developmental Disabilities. In New Mexico, the Aging and Long-Term Services Department (ALTSD) similarly is responsible for Older Americans Act Programs, waiver programs for seniors and adults, as well as the large Medicaid State Plan Personal Care Option. In 2005, ALTSD assumed responsibility for the Adult Protective Services Program. The developmental disabilities waiver remained within the Department of Health, when ALTSD was established; however, ALTSD is evolving and the transfer of those developmental disability programs to it is under discussion as a future consolidation. In Minnesota, Continuing Care, one of the major units in the Department of Human Services houses the Aging and Adult Services Division, which is responsible for all the Older Americans Act services delivered through the Area Agencies on Aging, the Medicaid waivers and other community care for Seniors, the ombudsman program, and a variety of protection and benefit counseling programs. Florida and Pennsylvania are both organized with high level Departments of, respectively, Elder Affairs and Aging, both of which administer Medicaid community care programs for older people and all Aging Network programs. Thus, all 8 States achieved sufficient integration related to aging services to locate the Aging Network within a

governmental unit responsible for LTC for seniors, but with varying responsibilities for programs affecting other populations.

All 8 States have integrated their Aging Network activities operationally with their Medicaid waivers for seniors. Texas, Vermont, and Washington have integrated those functions into an agency with a much broader mandate in terms of responsibility for added populations and institutional as well as community care. In Arkansas and New Mexico, the agency housing the Aging Network also is responsible for some programs for younger people with physical disabilities.

As an example of highly integrated operations for LTC under Medicaid, the ADSA in the State of Washington manages the financial and functional eligibility at the front end of service, the field operations for care planning and implementation, and the payment function at the back end of service, using a single automated assessment and care planning tool to assist with these functions. To illustrate more fragmented operations, in the State of Florida various State agencies are responsible for care planning and authorizing services, but until bills arrive and are paid by the Agency for Health Care Administration (the Medicaid agency), the operational agencies such as the Department of Elder Affairs or the Agency for Persons with Disabilities (among others) do not know how much of their budgets they have expended on services to the populations of interest.

Quality Assurance or Monitoring. Under *monitoring*, we group quality inspection and quality improvement functions. These include the federally mandated survey and certification of nursing homes that each State must conduct and any State programs for quality assessment and improvement for Medicaid waiver programs), and any programs for consumer protection. The States of Washington and Texas have grouped most of these quality and protective programs together along functional lines and located them within the same sub-entity of ADSA and DADS respectively, and in the same general entity responsible for planning and operations. (An exception in Washington is the state's free-standing ombudsman agency.) In both Texas and Washington, the inspection and quality assurance for nursing homes and institutions for developmental disability are closely linked to inspection and quality assurance for HCBS. This is in contrast to States where the nursing home survey and certification function is divorced from other QI activities and from program operations. Quite often, the certification and quality functions for developmental disability providers are vested in the same agency responsible for field operations for that population, whereas the same level of integration is not found for aging and other disability programs. In systems with an integrated data system, the monitoring functions offer information to guide planning and programs. Washington illustrates the most complete information system because the initial and ongoing assessment data form the basis for developing information about quality at the level of individual providers and for generating displays of aggregate information on specified parameters.

Integration of Programs

Closely related to the integration of functions is the integration and articulation of various Medicaid programs in waivers and State plan, and the coordination of Medicaid programs with other State-funded programs or State-administered and federally funded programs in community care and in institutions.

Integration of programs within Medicaid. To the extent that a State manages all its Medicaid State plan services and its sections 1915 and 1115 waivers together, it could be said to have a higher level of programmatic integration. In Washington, for instance, all HCBS waivers (with the exception of the AIDS waiver) and State plan waivers are administered by the same entity. Vermont and Texas are similarly integrated in their Medicaid management. Generally speaking, the more waivers a State administers, the more likely that administration is diffused across agencies. However, even the administration of a single waiver can, in unusual circumstances be fragmented. Florida, for example, operates an HCBS waiver for aging and disability, where 4/5 of the clientele are aged and the remainder younger people with disabilities; two separate departments administer the two components of that waiver.

One of the most important aspects of programmatic integration concerns the relationship between the institutional programs under Medicaid and the HCBS programs. To the extent that a single entity can exercise some budgetary flexibility across those programs, rebalancing is enhanced. Arguably, rebalancing and overall quality are also improved when programs such as Medicaid nursing homes, ICF-MRs, State developmental disability institutions, home health, and Medicaid waivers and additional State-funded programs are operated by individuals who clearly understand the full range of programs and share the same goals for LTC in the State. Such common purpose is best achieved by frequent contact and may be enhanced by organizational integration. The introduction of innovations, such as variants of consumer directed care, is enhanced by that kind of understanding. An illustration from the State of Washington also drives the point home: ADSA contains both a unit for Community Care and a unit for Residential Services (whose functions include inspection of nursing homes); when the latter needed to close a nursing home for quality reasons, the case managers from the former unit were immediately available to effectuate plans for the continuing services and housing of residents in the facility.

Integration of State-funded or State-operated federal programs with Medicaid programs. Many States offer substantial programs with State funds, including Minnesota, Florida, Pennsylvania, Washington, and Texas. States vary in the extent to which State-funded programs are managed along with Medicaid programs. Furthermore, each State offers programs through federal programs, such as Older Americans Act programs and specialized programs for infants and pre-school children. States may choose to manage these earmarked federal programs within their general LTC programs. For example, in Texas, Vermont, and Washington, the Director of the larger entity for LTC is also responsible for the State Unit on Aging, and the Older Americans Act functions are housed within the respective lead organizations, namely, DADS, DAIL, and ASDA. In Florida, the cabinet-level Department of Elder Affairs manages a variety of programs for older people, including selected Medicaid waivers, several important state-funded programs (Community Care for the Elder, Home Care for the Elderly, and an Alzheimer's program), and all Older Americans Act programs. Thus, many of the operations of aging programs (though not all functions enumerated in the previous section) could be considered to be largely integrated within Elder Affairs, but LTC programs for older people are rather distinct from those for younger adults with disabilities.

Population-Specific Integration

The third form of integration relates to populations of consumers. Some States combine functions for all or most consumers within a single State administration. Other States develop distinctive structures at the State level directed towards different consumer groups. In that case, it is possible to operate highly integrated functions and programs at the State level for some target populations and not for others.

Aging Services, including aging LTC services, are often separated administratively from other LTC services. Similarly, Developmental Disability programs for adults and children are also typically managed separately from other LTC programs; this is particularly pronounced in Florida, though it occurs to some extent in Arkansas, Pennsylvania, and New Mexico. Sometimes programs for younger people with physical disabilities are grouped with Aging and sometimes handled separately; in Minnesota all programs for people under 60, including persons with chronic physical illnesses, physical disabilities, traumatic brain injury and AIDS are grouped together administratively, whereas Aging stands somewhat alone. Children's programs, particularly LTC programs for children with mental health needs are often separated

administratively. If LTC programs are consolidated across target groups, opportunities for useful learning and cross-fertilization occur, and a potential exists for a stronger commitment to a unified vision for LTC. However, when states have become integrated by target group, members of and advocates for various target populations typically become concerned that they will lose their ability to influence government and for their special interests and concerns to be heard.

In Minnesota, the main agency for LTC is the Continuing Care unit of the Department of Human Services. Continuing Care itself is separated into an Aging and Adult Services Division, a Disability Services Division, a Nursing Facility Rates and Policy Division, and a Deaf and Hard of Hearing Division. As its mission, the Disability Services Division “plans, develops and evaluates community-based services for Minnesotans with developmental disabilities, traumatic brain injuries, physical disabilities and chronic medical conditions who are also in need of public supports.” This Division engages in a full range of functions for the populations indicated, and has been positioned to take active steps to rationalize processes for assessment, budget planning, and quality assurance across its separate programs. Responsibility for the Elderly Waiver, on the other hand, falls to the Division of Aging and Adult Services, which also administers all Older Americans Act programs. Furthermore, for a subset of categorically eligible clients, the Elderly Waiver is now managed through a mandatory capitated Special Needs Plan (SNP) administered by a Health Programs unit completely outside Continuing Care. Finally, functions involving the nursing home sector, which affects seniors much more than the other populations, are not part of Aging and Adult Services. A separate unit within Continuing Care establishes rates and policies for nursing homes, and the Department of Health operates survey and certification. Thus, the State reflects partial efforts to integrate across populations. The Aging programs have, thus far, been kept rather separate, in part because of efforts to articulate them more closely with acute-care programs.

In Arkansas, the Division of Aging and Adult Services (DAAS) is the focal point for most of the functions related to LTC and for most of the populations, but the Division of Developmental Services (DDS) operates separately, administering a relatively large program of State-run regional institutions and HCBS services for persons with DD. In Arkansas, the degree of integration could be rated separately for DD programs and all other long-term support programs.

Centralization versus Decentralization

Even small States (such as Vermont) are comprised of multiple counties and geographic districts for the administration of various LTC services (for example, Planning and Service Areas for Area Agencies on Aging, mental retardation districts, and mental health districts). Larger and/or more populous States are likely to have even more geographic divisions. A State’s LTC systems can be viewed as more or less centralized in terms of whether policies and decisions are made centrally and implemented uniformly throughout the State. To the extent that such intrastate consistency occurs and discretion at the local level is minimized, States may be better able to manage their total LTC programs and better bring about rebalancing.

One of the most notable strategies for centralization is the development and Statewide use of a single assessment tool for all LTC populations or (less consolidated or integrated but still centralized) for specific populations or programs. Another strategy for centralization is the use of State employees to conduct initial eligibility and functional assessments or to manage care. States can and do achieve uniformity by contracting these functions to local governmental or

nongovernmental entities, but minimizing variation requires considerable training and monitoring. Licensing, quality assurance, and consumer protection also may be centralized or decentralized, and to the extent that the functions are vested in local authorities, state-wide rules, training, and monitoring are needed to achieve uniformity.

At the level of LTC program management, the extent of centralization can

A uniform State-assessment tool and related protocols can be a force for and sign of centralization of LTC within a State.

be assessed by the number of entry points into the system at the local level. Whereas a centralized system allows all LTC populations to access programs through a single type of entry point (local LTC offices or virtual offices through Internet and phone services), more decentralized systems operate multiple entry points, for example, using AAAs for elder services and mental health agencies for that population.

Clearly centralization of program operations is more likely if the State structures are integrated and coordinated. To illustrate, aging services in Pennsylvania are accessed and managed through 52 Area Agencies on Aging (AAAs), largely contiguous with counties. The AAAs follow their own practices to allocate services based on the assessment, and they set their own rates for services. Until recently, the State has not monitored the performance of case managers. The Long-Term Living Council set as a priority the review of case management practices and found substantial variation among AAAs in the amount of services a consumer with particular assessed needs would receive. Until recently, Minnesota counties had a great deal of discretion in details of LTC programs, but that system too is moving towards greater central rationalization. In contrast, Washington State uses State employees for initial assessments; furthermore the State assessment form creates an algorithm for service plan amounts based on assessed needs. A case manager can manually over-ride the assessment tool but would need to justify that decision. Further, central office State employees perform quality assurance for the case managers, a function made easier through auditing the uniform assessment and information system prior to visits to local assessment units. Other markers of centralization include state-wide training; State monitoring and oversight of local operations, State reallocation of resources among local units to meet overall needs; and local understanding and commitment to overall goals of the State program.

State-by-State Discussion

This section briefly describes each State's organization for LTC. Table 3 includes ratings of our impression of the extent to which each State is integrated and centralized in its organization for LTC, using a high, moderate, or low classification. The narratives sketch out the major features that explain those ratings. The ratings are impressionistic rather than applications of empirical formulas. It is also noted that many of the States are evolving their organizations along these parameters; it is likely that some of these ratings will change in the near future.

Table 3: Ratings of Integration and Centralization in LTC Organization

	AR	FL	MN	NM	PA	TX	VT	WA
LTC Structure								
Integration	Moderate	Low	Moderate	Moderate	Low	High	High	High
Centralization	Low	Low	Low	High	Low	Low	High	High

Arkansas

Arkansas operates an umbrella agency, the Department of Health and Human Services, established in 2006 when the functions of the Department of Health were merged with the already large umbrella agency, the Department of Human Services. Appendix Figure A1 illustrates that structure. One arm of the Department, under the direction of a Deputy Administrator contains parallel Divisions for Aging and Adult Services, Developmental Disabilities, Behavioral and Mental Health, Medical Services (Medicaid), County Operations, and a Budget and Administration unit. The other arm of the Department includes more of the traditional social service units, such as the Division of Family and Children, but it also includes the Division for the Blind. This organizational chart suggests considerable fragmentation. As

Figure A2 shows, however, the Division for Aging and Adult Services (DAAS), under the long-time direction of Herb Sanderson, has integrated considerable responsibility for community LTC for all but persons with developmental disabilities, including managed care efforts, and innovative grant-funded efforts, planning, and developmental programs; links to the Developmental Disability Division and the Division for the Blind are maintained through participation in the Governors Integrated Services Task Force, the Olmstead planning group. Although DAAS does not directly control the institutional budget, DAAS is working on an innovative Next Choice program that would cash out nursing home care. The lack of a single entry point for LTC services is a concern and the State is working on that issue in its System Transformation Grant. State employees assess functional ability, which is a force for some centralization, largely because all but one Area Agency on Aging are direct service providers in Arkansas. We have rated Arkansas as moderate for Integration and low for Centralization.

Florida

Florida has an unusual State Government structure with an elected cabinet. Formerly, five cabinet officers were elected, but effective in 2003 that number has been reduced to 3: the Attorney General, the Chief of Finance, and the Commissioner of Agriculture. The Cabinet system is comprised of a large number of appointed boards, commissions, departments, and agencies. At present, five separate entities have responsibility for operating parts of the LTC system, including the Department of Children and Families, the Department of Health, the Department of Elder Affairs, the Agency for Persons with Disabilities (which until 2004 was a program within the Department of Children and Families), and the Agency for Health Care Administration (AHCA), where the Medicaid Agency is housed. Figure A3 shows schematically how LTC waiver and State programs are distributed across the multiple agencies. AHCA is the focal point for management of the budget and for LTC planning, and the nursing home survey and certification agency is also within AHCA, which operates 11 field offices (see Figure A4 for the organization of AHCA). The Department of Elder Affairs operates, among other programs, several Medicaid HCBS waivers, 2 large state-funded programs called Community Care for the Elderly (CCE), and all the usual programs under the Older Americans Act. The latter are run through 11 Area Agencies on Aging and a much larger number of lead agencies for CCE and the Aging and Disability HCBS waiver. The local administration of LTC is decidedly decentralized, especially for the Aging programs, in part because of a 3-level system through Area Agencies on Aging to Lead Agencies of service providers, as well as number of programs that are managed directly by Managed Care Organizations. We have rated Florida as low on Integration and Centralization.

Minnesota

The Minnesota Department of Human Services (DHS) is an umbrella agency, which is included in the Governor's Health Cabinet (See Figure A5). DHS is organized with agency-wide functions, including the Medicaid agency, Finance, and Policy, and 4 main operational units, each headed by an Assistant Commissioner: namely, Continuing Care, Health Care, Children and Family Services, and Chemical and Mental Health Services. Continuing Care, the unit most associated with LTC, is divided into Aging and Adult Services, Disability Services, Nursing Facility Rates and Policy, and smaller units for Deaf and Hard of Hearing Services, and HIV/AIDS Management Operations (See Figure A6). Formerly located in a suburb of St. Paul quite removed from the main offices of the Department of Human Services, the Disability Service Division was recently re-located to offices in St. Paul in the same building as the Aging and Adult Services Division, and some effort is underway for joint planning for LTC, furthered by regular management meetings within Continuing Care. However, the major thrust for Aging Services -- managed LTC initiatives -- is within the jurisdiction of the Assistant Commissioner for Health, not Continuing Care. In Minnesota, the LTC strategies for Seniors differs from those for the populations served under the other 4 HCBS waivers; joint planning has been undertaken for the latter to achieve uniform assessments and individual budget allocation methods. Minnesota is historically a State with strong counties, and each county has separate lead agencies for Aging and for Developmental Disabilities. We have rated Minnesota as moderate in Integration and low in Centralization.

New Mexico

In New Mexico, a number of Cabinet level agencies are involved in Long-Term Care, most notably the Department of Aging and Long Term Service (ALTS), the Department of Human Services, and the Department of Health (see Figure A7). The Legislature established ALTS with the intention of consolidating long-term care and disability activities and establishing a focal point for planning; the organization of ALTC is shown in more detail in Figure A8. At present, the Developmental Disability Services are within the Department of Health. Income support services and eligibility operations are the responsibility of the Department of Human Services. With the mandate of the Governor and the Legislature, these and other organizations collaborate closely. New Mexico's Behavioral Health Program established a precedent for multiple agencies contributing funds and jointly issuing a request for proposals for an entity to manage behavioral health efforts on a capitated basis. A similar effort is underway for managed LTC initiatives. New Mexico is a vast State with most of the population centered around Albuquerque and nearby Santa Fe; with sparse population in much of the rest of the State and large numbers of Indian tribal entities, some centralization has been needed for the management of State programs. As indicated above, eligibility assessment is managed through a contract to an HMO based in Albuquerque, which in turn organized face-to-face assessments by home health nurses. Nurses and nursing agencies involved in these assessments and initial care plans are not eligible to provide services under the waivers. We rated New Mexico as moderate in Integration and high in Centralization.

Pennsylvania

Pennsylvania is in transition for LTC, with the major impetus for reform coming out of the governor's office. Shortly after his election, Governor Rendell established his Office for Health Care Reform, with responsibilities for both acute care and LTC, which in Pennsylvania is called

Long-Term Living. The Health Care Reform effort is led by a Cabinet-level official, but, by design, the dedicated staff is lean and additional assistance is drawn from operational Departments. The major departments involved in LTC in Pennsylvania are Public Welfare, where the Medicaid agency is housed as well as many of the HCBS waivers and disability programs (see Figure A9), the Department of Aging (see Figure A10), and the Department of Health, where the Nursing Home program is managed. After an Interagency Retreat, the Long-Term Living Council was established in the Fall of 2005 to give focus to Long-Term Care Initiatives. It has a small staff, headed by Michael Nardone, formerly of the Department of Welfare, and comprised of cross-agency teams. The Commission members are the directors of the Departments of Aging, Public Welfare, Budget, Policy, the Office of Health Care Reform, and the Deputy Chief of Staff. The Commission meets every two weeks and has established priorities, many of which are aimed at gathering better information about State-wide variation in assessment and case management, and rationing procedures. Until recently, those activities were not audited at the State level, and multiple State data systems make such monitoring difficult. Other Commission priorities are downsizing institutions and developing transition and diversion programs. We have rated the State as low in Integration and Centralization.

Texas

The State of Texas undertook a massive reorganization of Health and Human Services activities, merging and relocating agencies to create its umbrella Texas Health and Human Services Commission (HHSC), headed by an Executive Commissioner (Figure A11). The Medicaid program, various rate-setting operations, the ombudsman program, TANF, and eligibility functions are located within the HHSC. Within the Commission are four parallel organizations with similar structure, each headed by a Commissioner: the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the Department of Family and Protective Services (DPS), and the Department of State Health Services (DHS). DADS, which is organized with 3 Centers and 4 Departments, encompasses most of the functions related to LTC for all populations, and is organized across functional lines so that access services, quality assurance, and state operations (for example) are conducted across target population lines (see Figure A12). Moreover, the Provider Relations, Access and Intake, and Regulatory units all include both institutional and HCBS services. DARS houses services for the blind, services for the hard of hearing, rehabilitation services, and early childhood education programs, and, thus, also relates to disability programs. Substantial collaboration occurs across the units in HHSC, and representatives of all the Commissions sit on most HHSC task forces. As by far the largest State in the lower 48, and as a populous State with many large areas of urban concentration as well as vast rural areas, some decentralization is inevitable. Indeed, multiple entry points into the system are available based on target population, and the State does not exercise direct control over contracted local agencies. However, some efforts are underway at present to develop stronger centralized functions. We rated Texas as high for Integration and low for Centralization.

Vermont

Health and human services in Vermont are organized with an umbrella agency, the Agency for Human Services, which is comprised of the Department of Health, the Office of Vermont Health Access (i.e. the Medicaid Program), the Department of Children and Families, the Department of Corrections, and the Department of Disability, Aging and Independent Living

(DAIL) (see Figure A13). Within the recently established DAIL are clustered almost every organization related to LTC, including the Division of Licensing and Protection, the Division of Aging and Disability Services, the Division of Blind and Visually Impaired, and Vocational Rehabilitation (see Figure A14). Financial eligibility is assessed by the Department of Children and Families. Although considerable local involvement occurs in Vermont despite the small size of the State, the functional ability for seniors and persons with physical disabilities has recently been undertaken by State employees to achieve greater consistency. We rated Vermont as high in Integration and Centralization.

Washington

The State of Washington is organized with an umbrella Department of Social and Health Services within it, the Aging and Disability Services Administration (ADSA), headed by an Assistant Secretary, is responsible for all LTC functions. Figure A The ADSA contains Divisions for a Home and Community Service, Residential Care Services, Developmental Disabilities Division (formerly its own unit with an Assistant Secretary), and a Management Services Division. ADSA is particularly well integrated by function (including budgeting, planning, operations, quality assurance, and financial eligibility), program (including State Plan, waiver, and State programs), and target populations. Washington utilizes State personnel for eligibility and functional assessments, and a state-wide, modularized, and computerized assessment and care planning system that tends to standardize operations and allocations across the State. Thus, despite a different entry system for developmental disability services, the State can be rated as high in centralization. We rate Washington as high in Integration and Centralization.

Conclusions

The 8 States in this Study exemplify variations on the theme of State organization for long-term care and long-term support systems. In these 8 States, each in the process of rebalancing, considerable attention has been given to how the State should organize for long-term care, and some ambitious changes have been put in place that are, in some instances, still being implemented. Taken together, the States show that many ways are possible to organize for performance of long-term care functions. The trends seem to be toward:

- Bringing LTC functions together in the same agency;
- Developing greater articulation among Medicaid LTC programs (including waiver and State Plan services, and institutional and community care services) and between Medicaid LTC programs and other state-operated or State-funded LTC programs.
- Integrating programs across multiple groups of consumers.
- Creating more centralization of long-term care functions across a State.

We began this Topic Paper with some questions that are often raised in the field. Based on the analyses conducted here, tentative responses follow:

- Should state organizations that manage institutional and community based care be integrated into a single State entity?

We find considerable support for such organizational mergers in order to maintain a focus on the shared goals of rebalancing, to pinpoint accountability for outcomes, and to render budgetary allocation and reallocation more flexible. We found no reason to favor a separate cabinet-level agency over a unit within an umbrella agency. Further, even in a single LTC authority, communication among key department heads needs to be frequent, just as collaborating organizations require frequent communication in more fragmented systems.

- How can budgetary responsibility be best aligned with LTC program responsibilities?

State legislatures bear ultimate responsibility for budget adjustments. The most effective arrangement for rebalancing appears to be a situation where the same entity responsible for operations develops the forecasting or fiscal analysis on which the budget allocations are based and, moreover, has the ability to move money between institutional budgets and HCBS budgets, across programs, and across consumer groups.

- Should the Medicaid agency delegate responsibility for functional and financial eligibility for Medicaid LTC programs (including waiver programs) so that the initial assessments of functioning and financial responsibility are integrated into an organization bearing overall accountability for LTC?

We found widespread consensus that functional eligibility determination should be integrated with other functions in long-term care planning, delivery, and oversight. All 8 States had achieved this integration or were working toward it. Determination of financial eligibility often can take months for individuals not yet qualified for Medicaid on a categorical basis and receiving income support. Only Washington among the 8 States had achieved that degree of integration (a status acquired previously in Oregon).

- What State level structures and processes best promote communication, cross-fertilization, and articulation of services between long-term supports and other relevant service sectors, such as acute care, housing, mental health, education, employment, and income supports?

We found some support for the idea that important collaboration and communication between LTC authorities and other governmental organizations is enhanced if the LTC authorities are consolidated.

- To what extent should policies and programmatic decisions on matters such as eligibility, service options, licensing, and rate-setting be taken at the State level as opposed to taken at local discretion?

LTC is delivered at the local level, and strong leadership is needed in local entry point organizations to make community care and consumer choice possible within the constraints of local conditions and resources. Nonetheless, some State-level centralization is important in terms of establishing equitable systems statewide. A uniform assessment tool or tools and state-wide training are indicated. At a minimum, the State requires an information system that allows it to manage resources and ensure quality across the entire State.

This paper was organized around two key organizational concepts: integration versus fragmentation, and centralization versus decentralization. Integration was further divided into 3 types: integration of functions, integration of programs (including institutional and HCBS), and

integration by target populations. These analyses lead us to hypothesize that integration of all 3 kinds and centralization further rebalancing goals. Integration across target consumer groups at the State level requires trust that the specific interests of any given disability group be maintained, and that links to specific provider networks be operational at the local level.

Since 2000, the trend to integrate through organizational merger and pinpointing of responsibility has been seen in Texas, Vermont, and Washington. Integration through inter-agency collaboration is illustrated in New Mexico and Arkansas. The highest level of integration is shown in Washington, where all LTC functions and programs for all populations (with the exception of an AIDS/HIV waiver) are unified in a single accountable department within an umbrella agency. In theory, a program can be well integrated by meeting the first two goals for a particular population; however some States report an advantage in moving the management of LTC for multiple populations into a single authority.

In future studies, it would be useful to develop objective indicators of each of the 3 constructs under the integration dimension and of centralization so that empirical analyses could be conducted exploring more definitively the link between rebalancing achievements and structural characteristics.

Appendix: Organizational Charts

- Figure A1. Arkansas Department of Health and Human Services, July 2006.
- Figure A2. Arkansas Division of Aging and Adult Services (DAAS), July 2005.
- Figure A3. Organizations Involved with LTC in Florida, August 2005
- Figure A4. Florida Agency for Health Care Administration (AHCA), August 2005.
- Figure A5. Minnesota Governor's Health Care Cabinet, August 2005
- Figure A6. Minnesota Department of Human Services, August 2005.
- Figure A7. New Mexico Governmental Structures for Long-Term Care, 2005.
- Figure A8. New Mexico Aging and Long-Term Services Department, June 2006.
- Figure A9. Pennsylvania Department of Public Welfare, August 2005
- Figure A10. Pennsylvania Department of Aging, August 2005.
- Figure A11. Texas Health and Human Services Commission, August 2005
- Figure A12. Texas Department of Aging and Disability Services (DADS), August 2005
- Figure A13. Vermont Agency for Human Services, August 2005
- Figure A14. Vermont Department of Aging, Disability, and Independent Living, August 2005
- Figure A15. Washington Department of Social and Health Services (DSHS) and Aging & Disability Services Administration (ADSA), August 2005

Figure A1. Arkansas Department of Human Services in August 2006

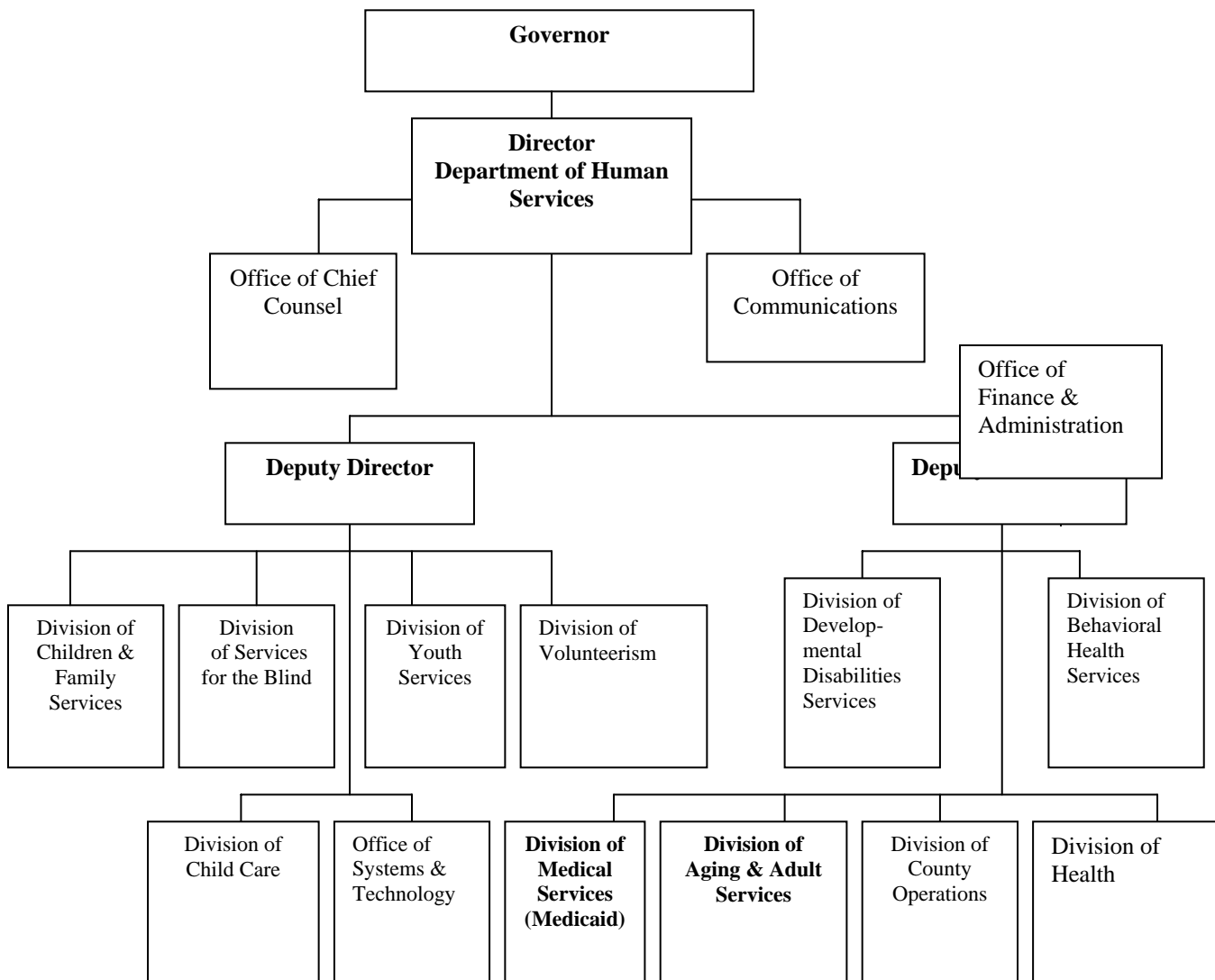
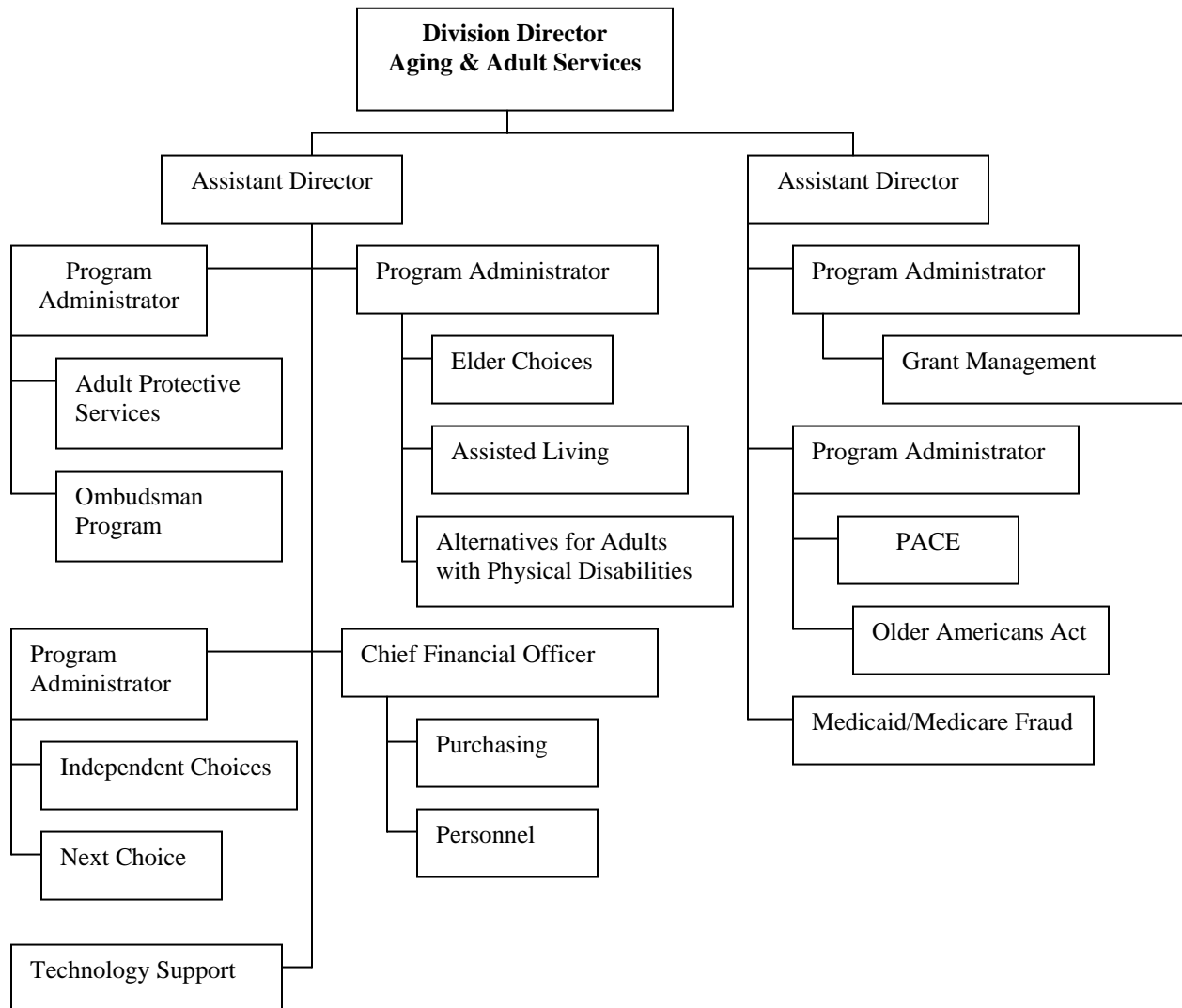


Figure A2. Arkansas Division of Aging and Adult Services, July 2005



**Figure A3. Organizations Involved with LTC in Florida, August 2005
(Schematic Diagram)**

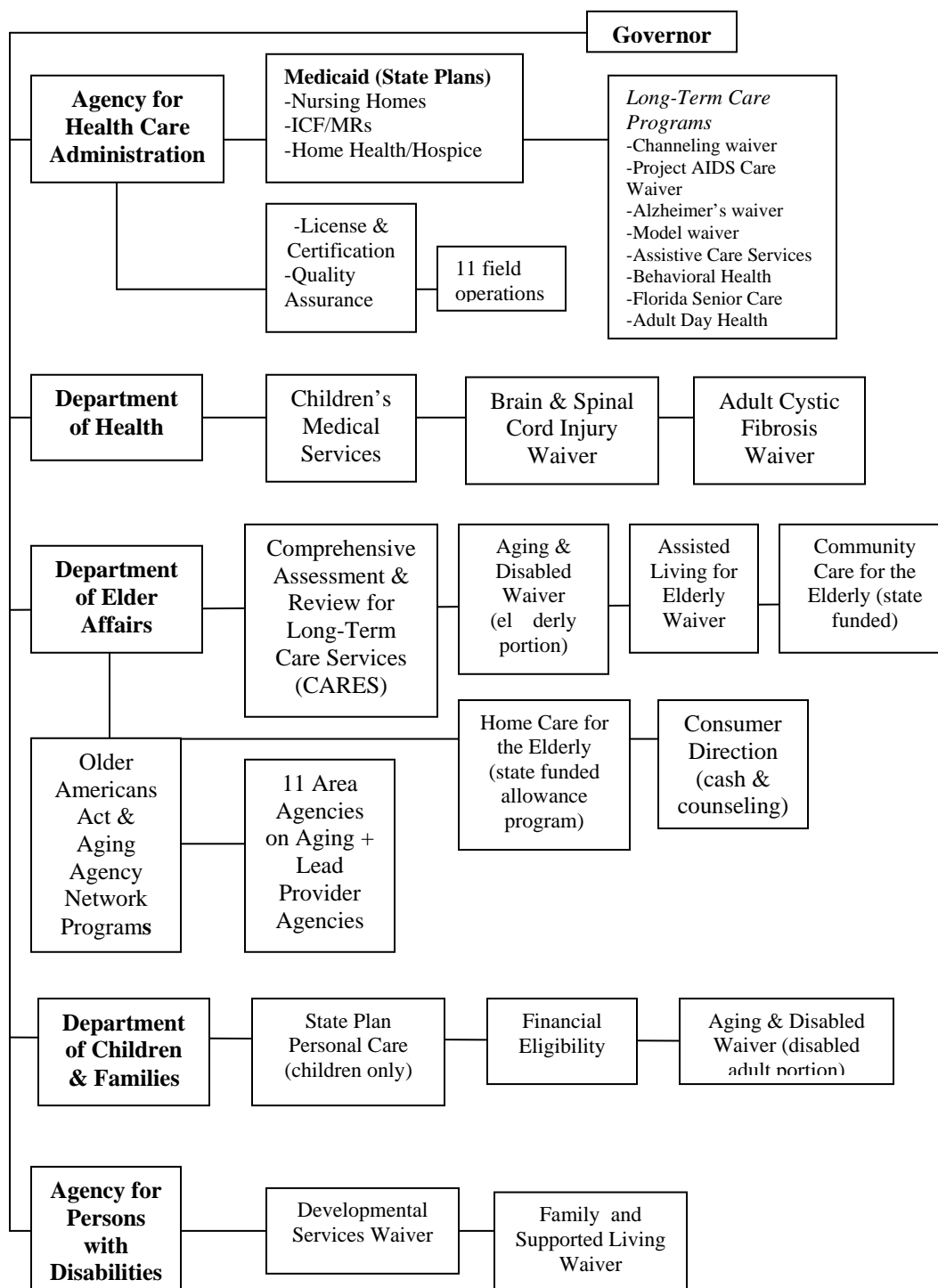


Figure A4. Florida Agency for Health Care Administration, August 2005

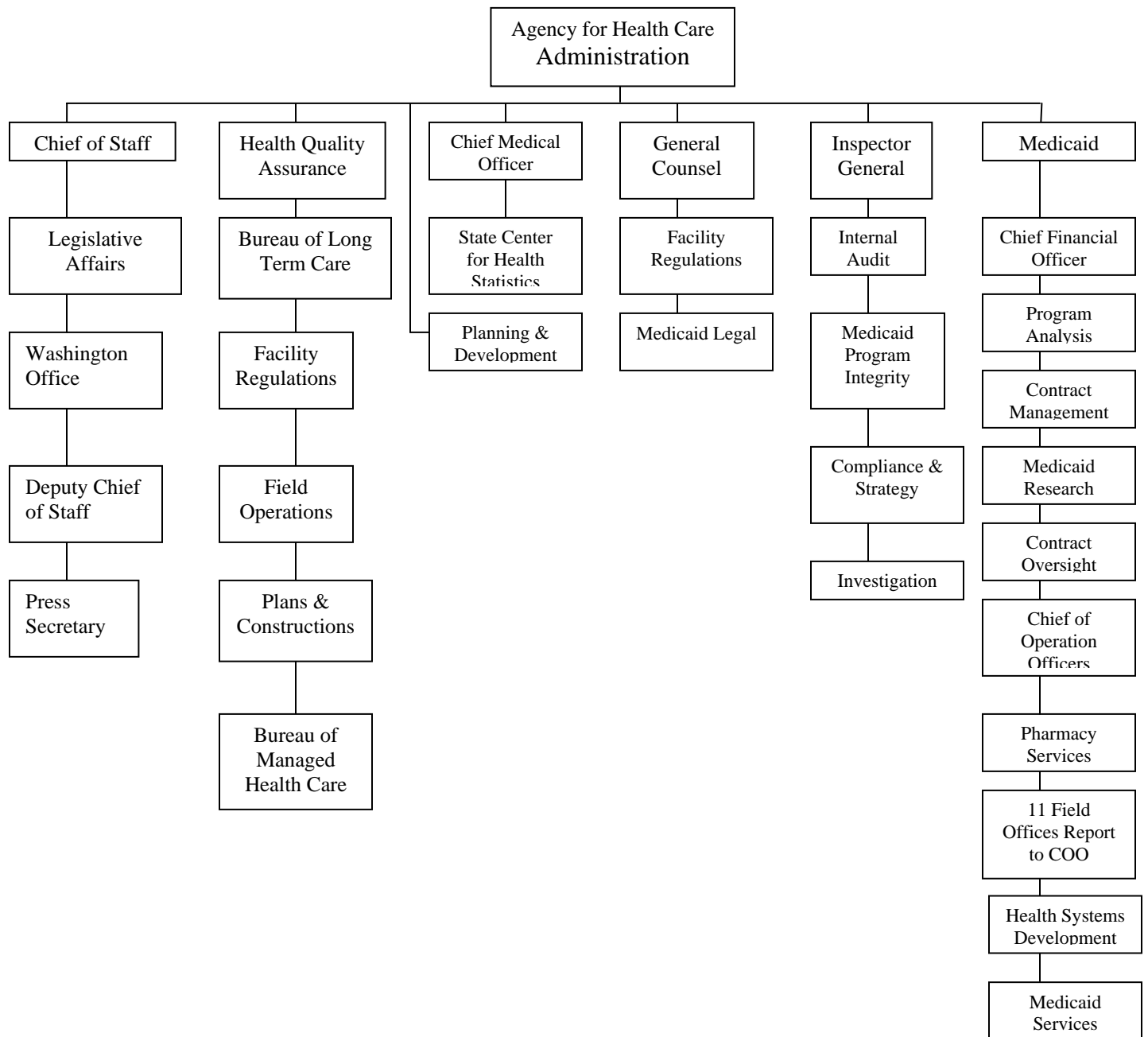


Figure A5. Minnesota Governor's Health Care Cabinet, July 2005

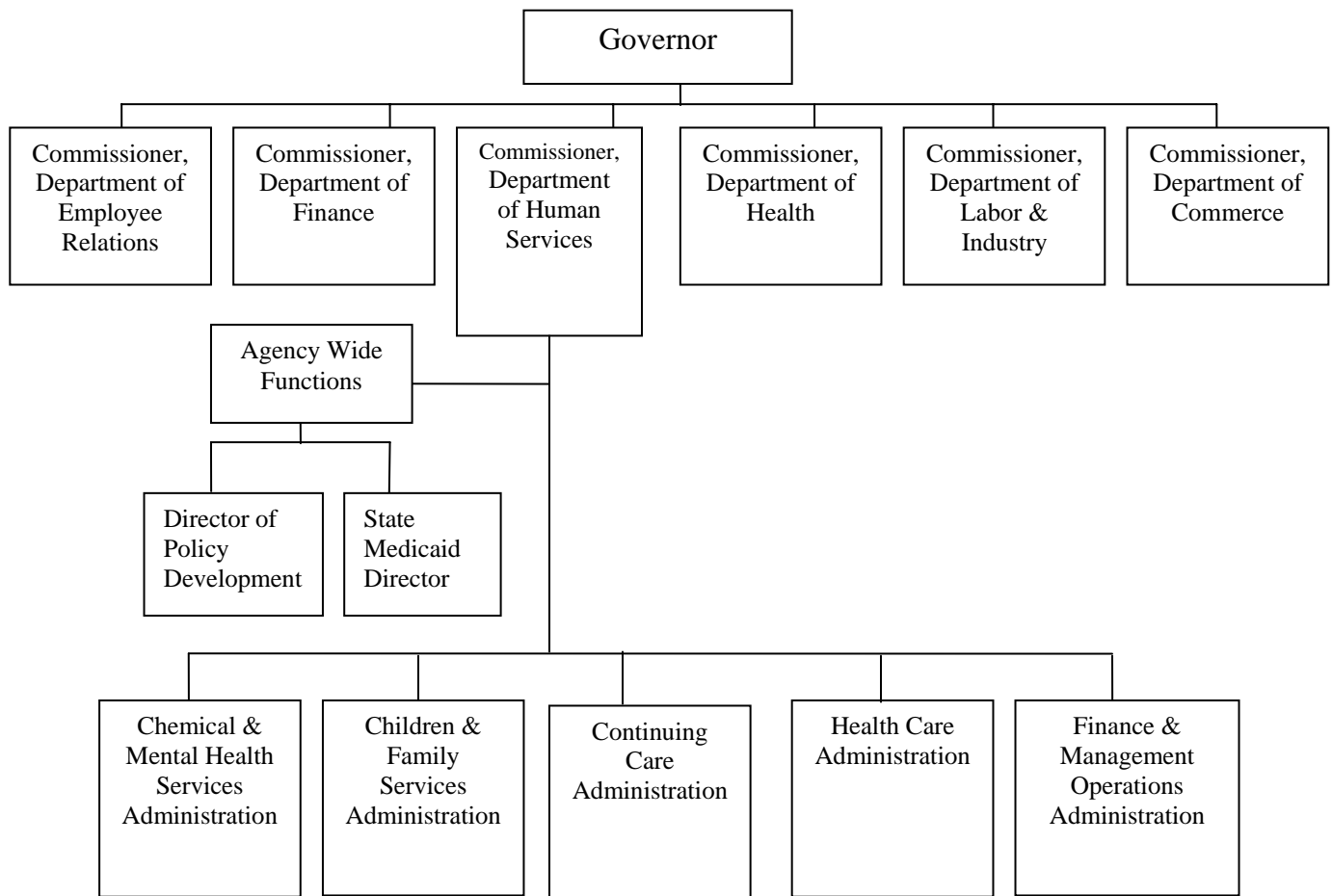


Figure A6. Minnesota Department of Human Services, August 2005

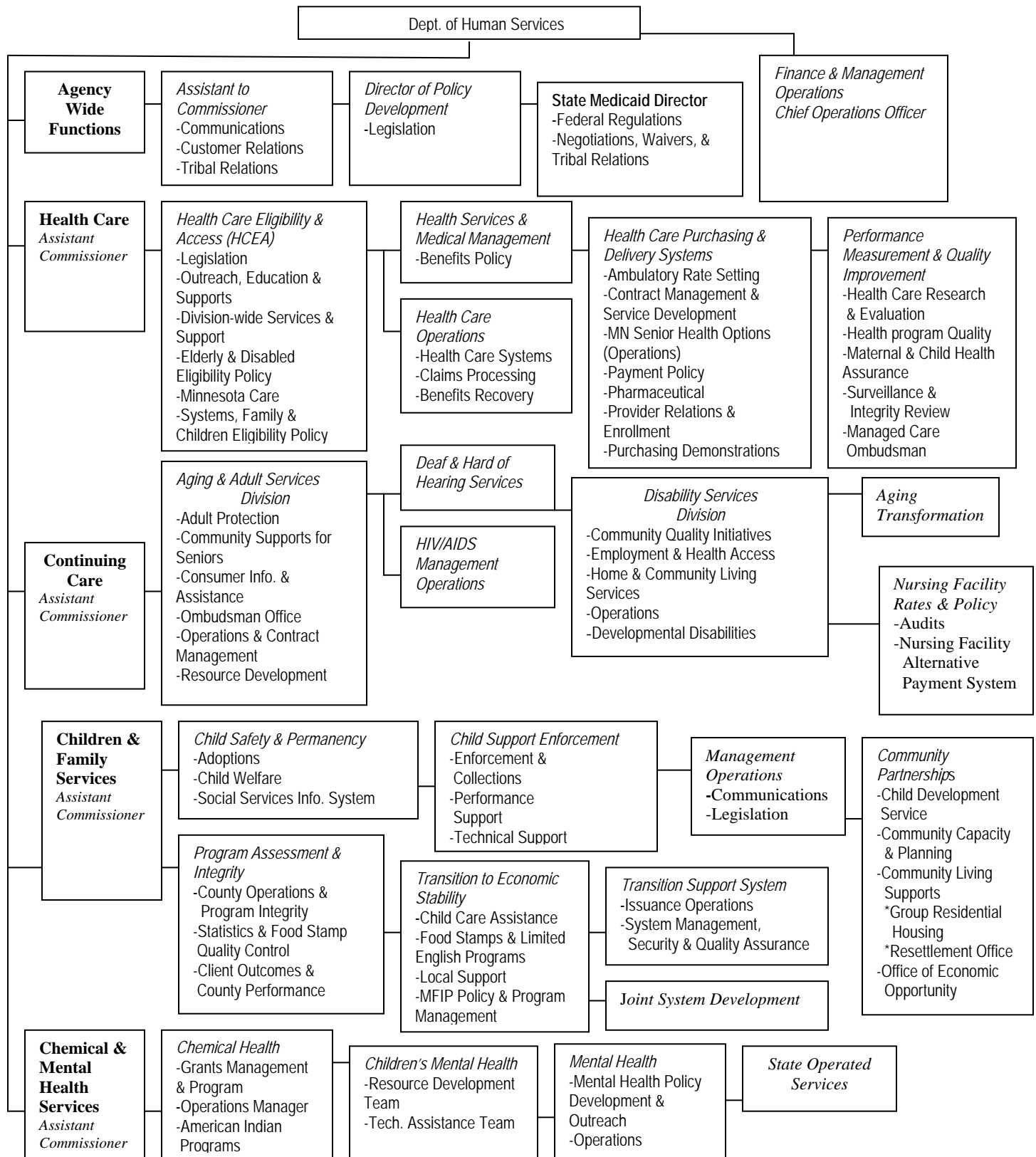


Figure A7. New Mexico Governmental Structures for Long Term Care, August 2005

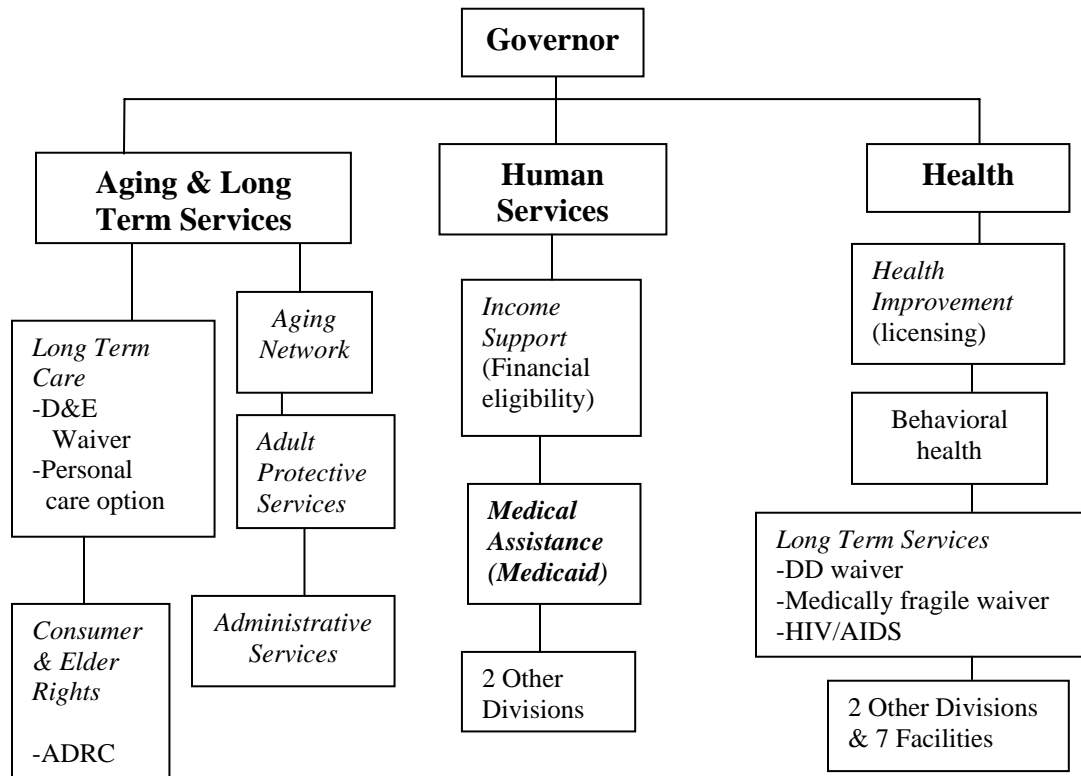


Figure A8. New Mexico Aging and Long-Term Services Department, June 2006

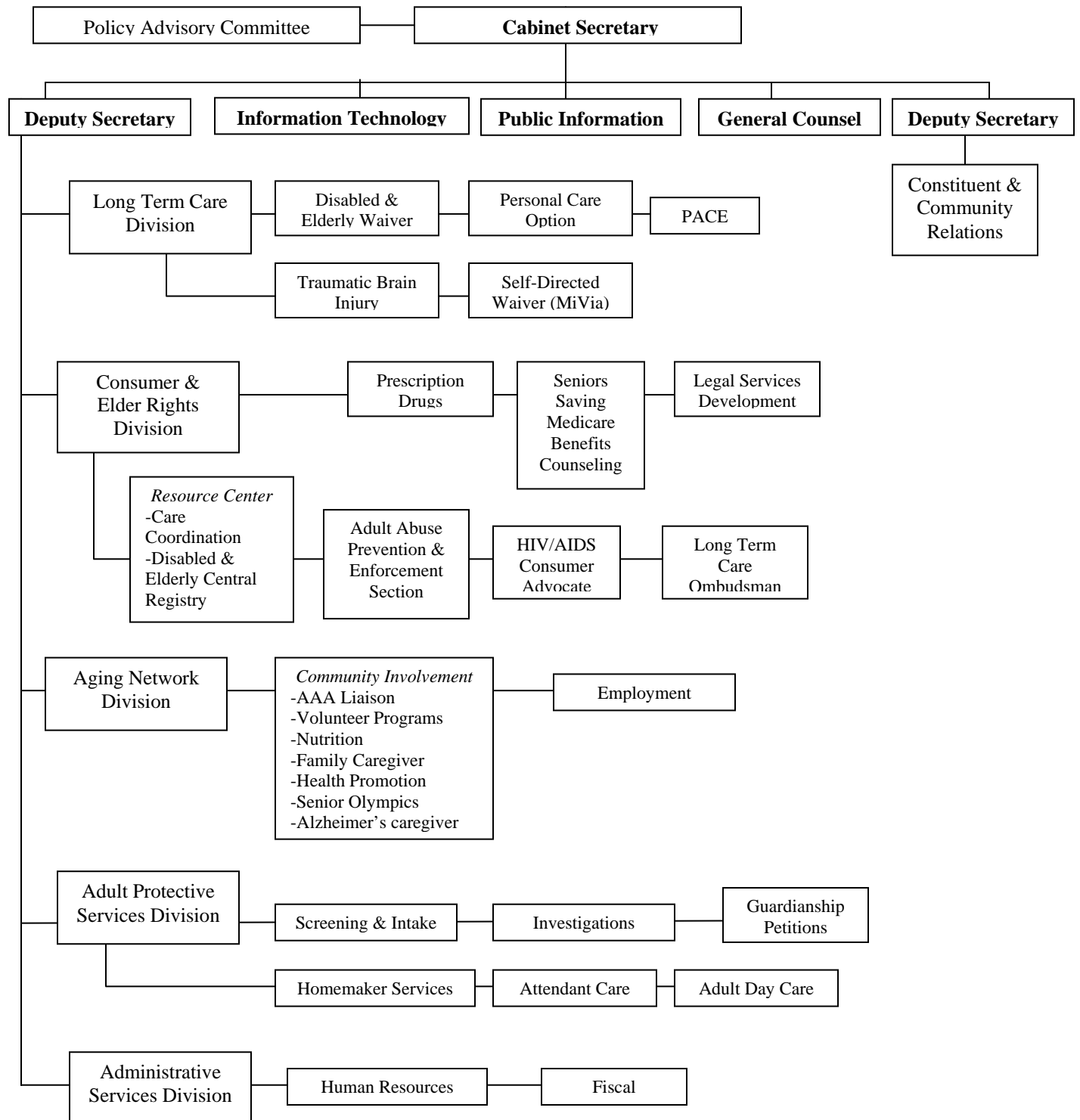


Figure A9. Pennsylvania Department of Public Welfare, August 2005

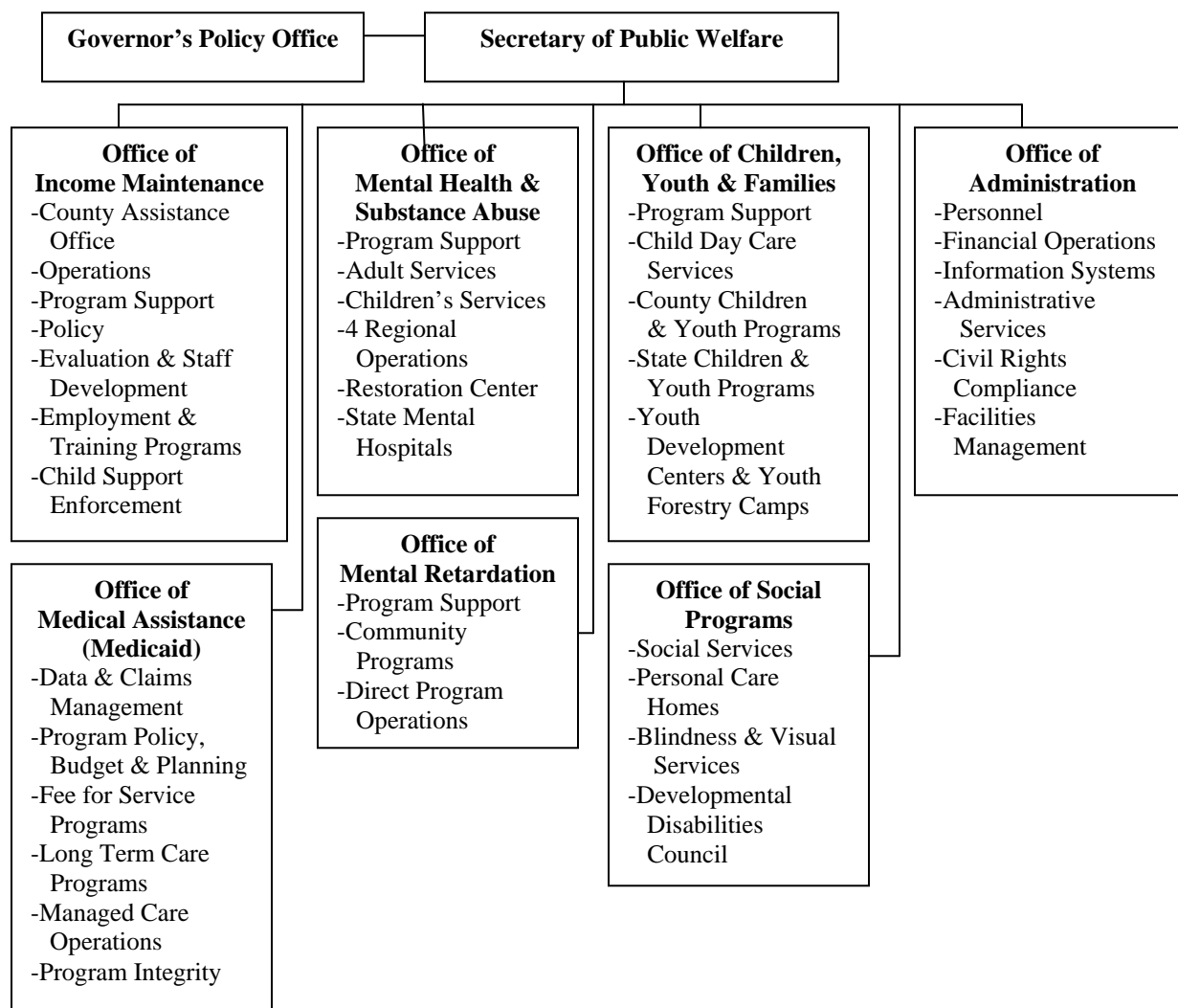


Figure A10. Pennsylvania Department of Aging, August 2005

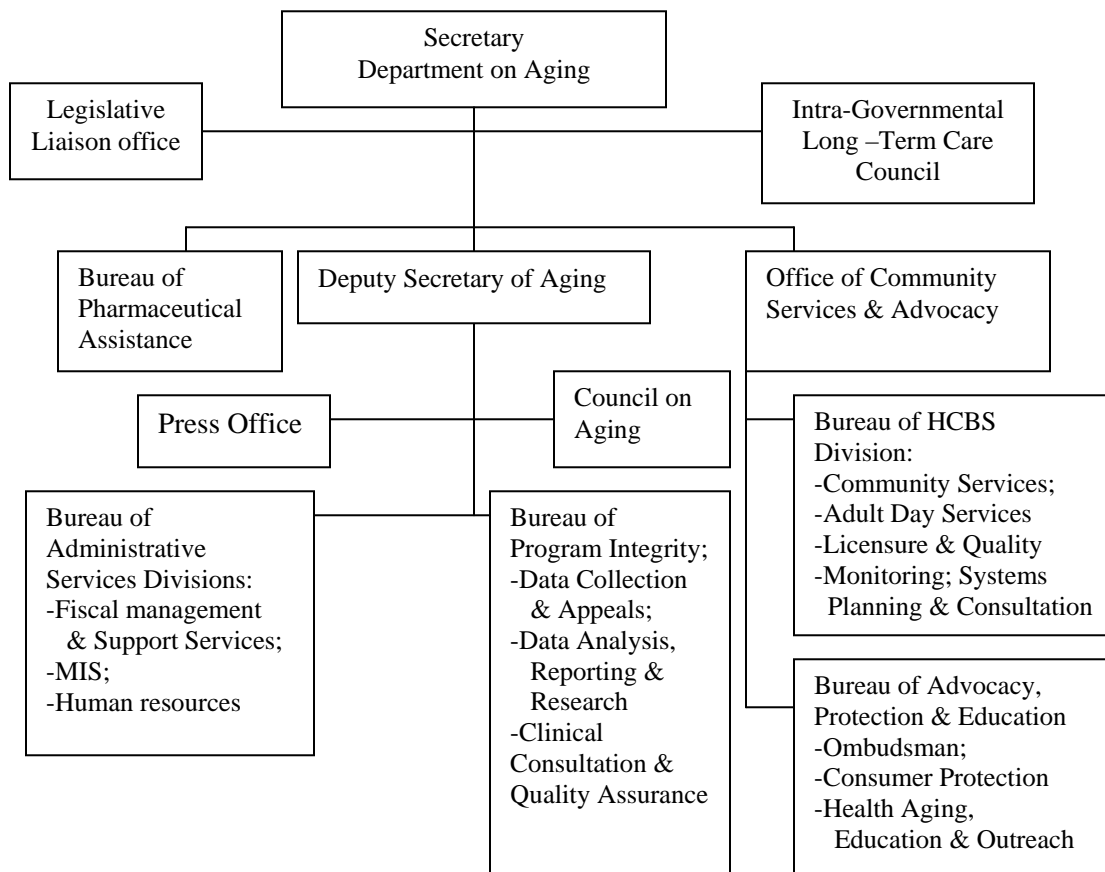
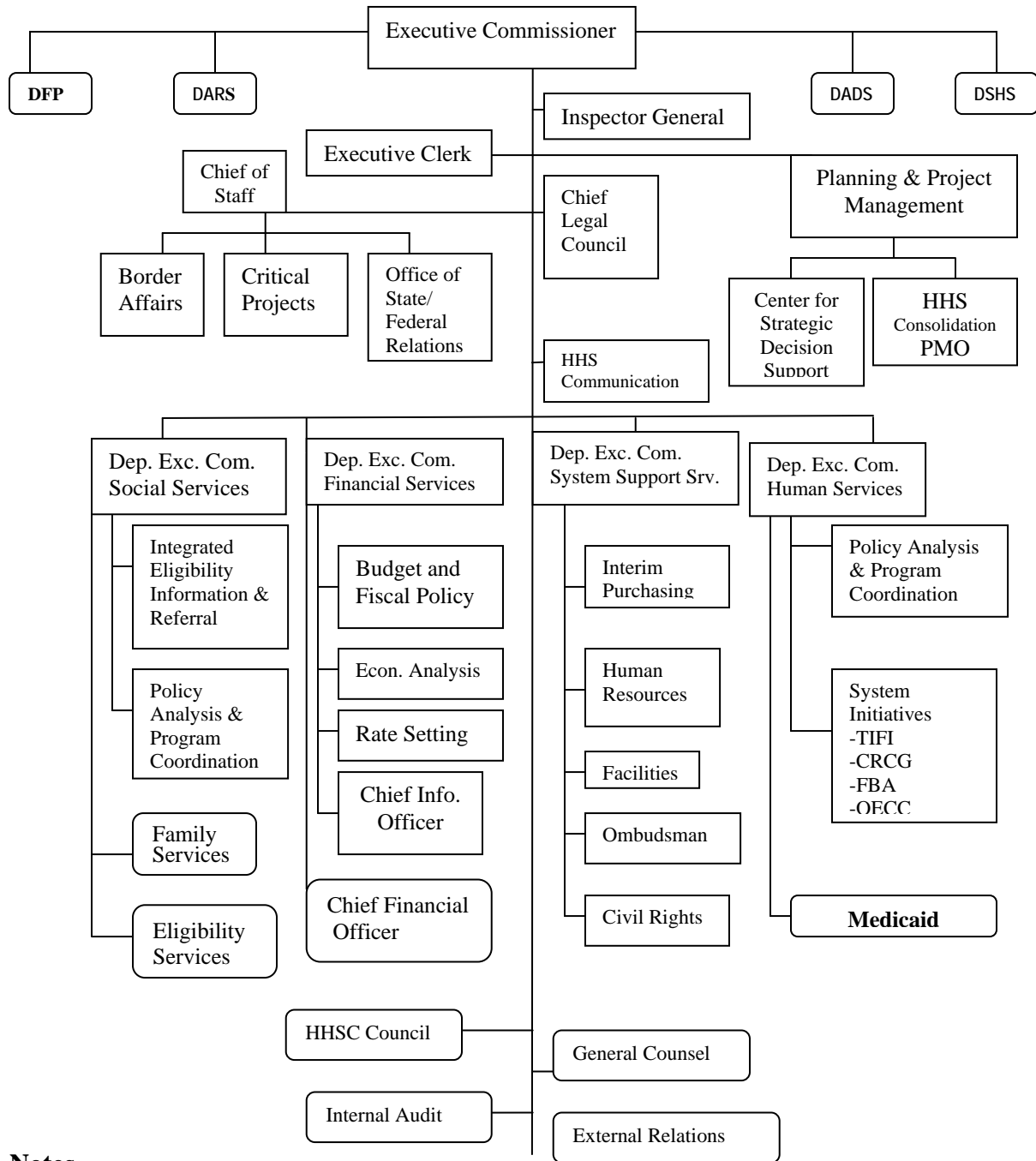


Figure A11. Texas Health and Human Services Commission (HHSC), August 2005



Notes

DFP - Texas Department of Family and Protective Services
DARS - Texas Department of Assistive and Rehabilitative Services
DADS - Texas Department of Aging and Disability Services
DSHS - Texas Department of State Health Services

The agencies listed above are the 4 operational divisions of the HHSC. Each is headed by a Commissioner, has an advisory Council appointed by the Executive Commissioner, and may have a Deputy Commissioner Structure. The other organizations on the diagram are the central functions of the HHSC. Figure A12 shows the detailed structure of DADS, the major organization where LTC is consolidated.

Figure A12. Texas Department of Aging and Disability Services (DADS), August 2005

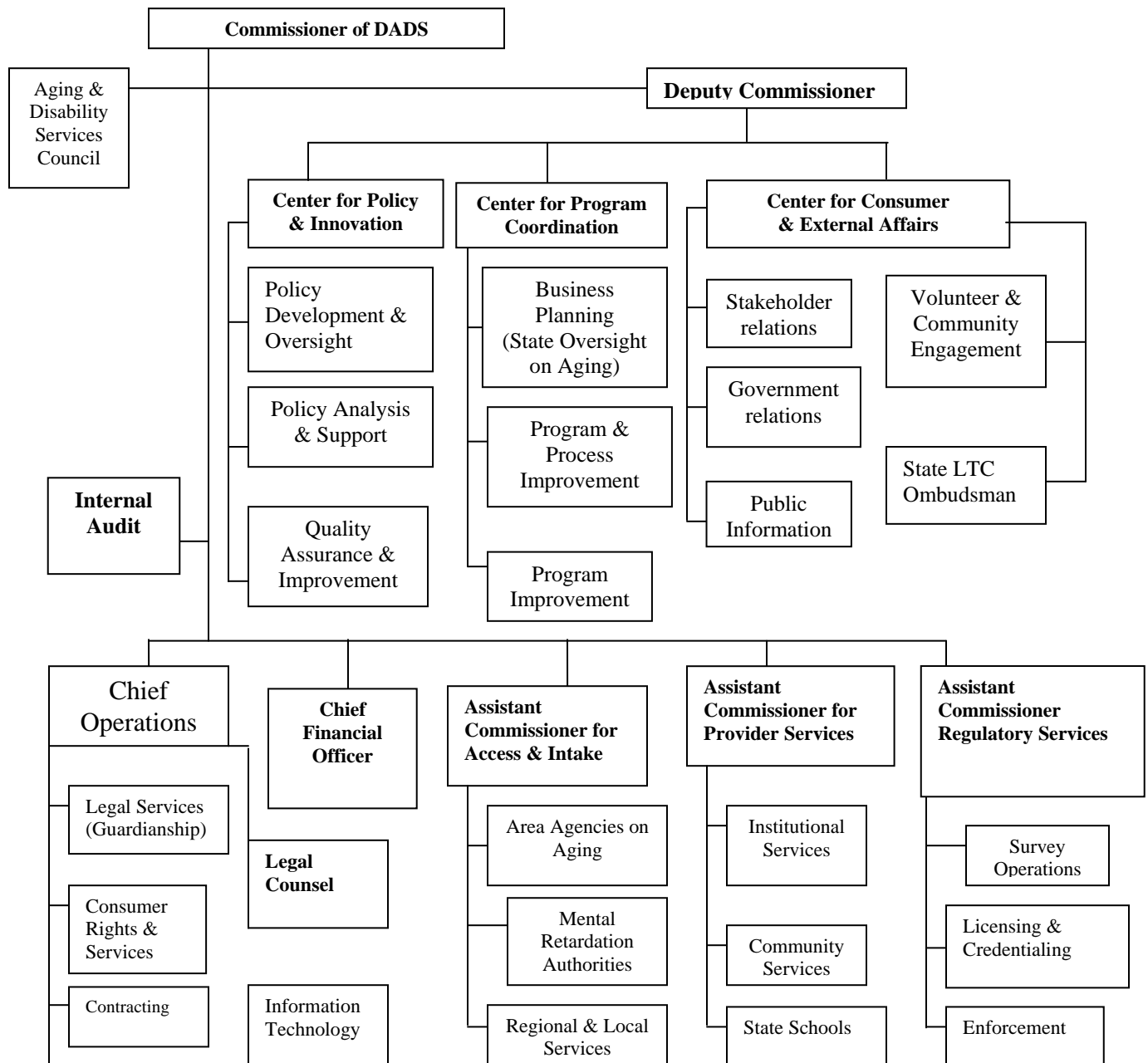


Figure A13. Vermont Agency for Human Services, 2005

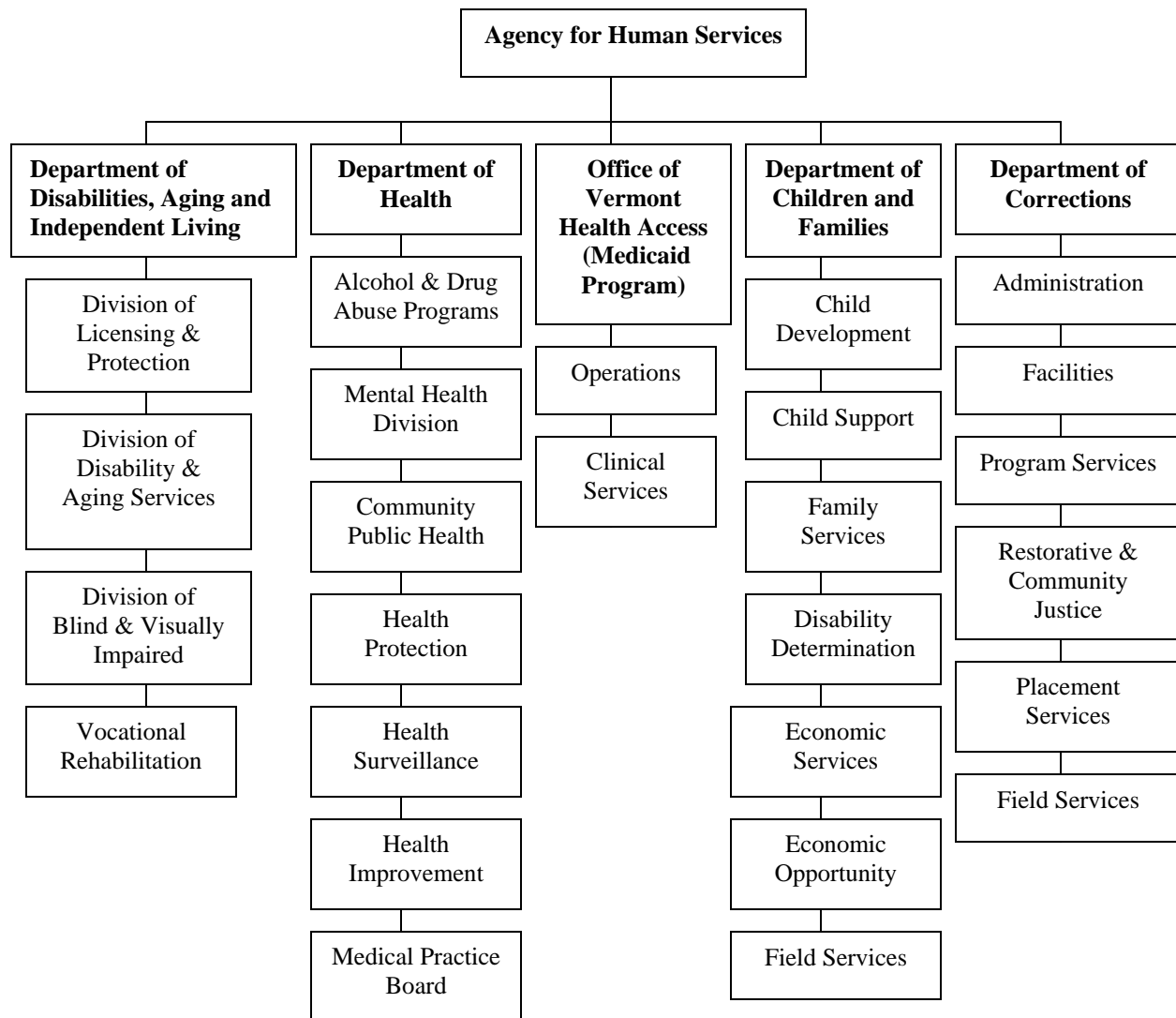


Figure A14. Vermont Department of Disability, Aging, and Independent Living, 2005

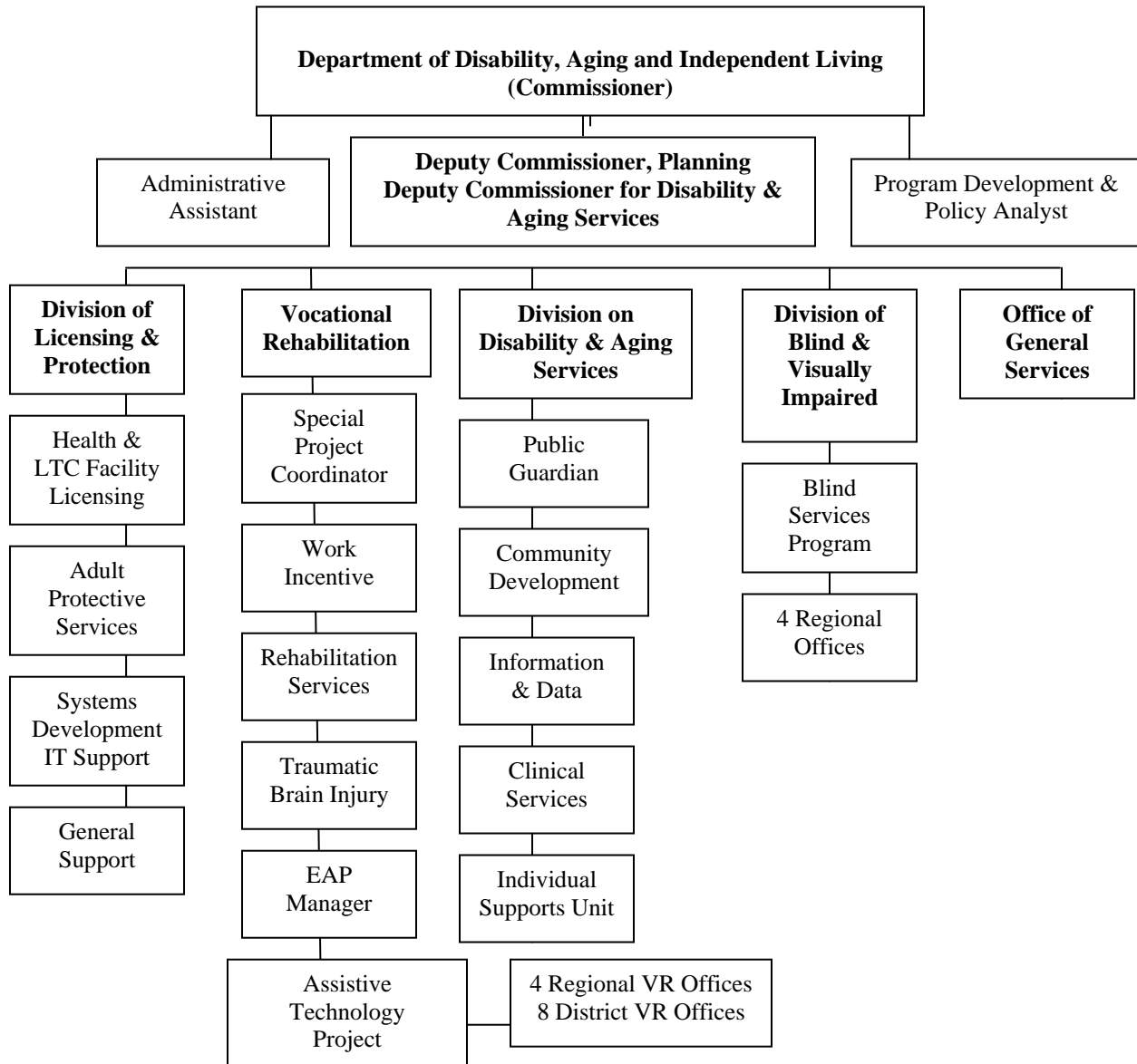


Figure A15. Washington Department of Social and Health Services (DSHS) and Aging & Disability Services Administration (ADSA) within DSHS, 2005

