SENATE CONCURRENT RESOLUTION NO. ___

BY TINSMAN

A Concurrent Resolution requesting the establishment of a planning group to develop a plan for unifying the state administration of services utilized by older Iowans age 60 or older.

WHEREAS, the provision of long-term living services to older Iowans is vital in enhancing the lives of older Iowans as well as the overall community life in the state; and

WHEREAS, providing the correct balance of long-term living services involves coordination of a variety of disciplines and programs, and activities of state governmental agencies; and

WHEREAS, the role of the state in administering long-term care services should be to streamline access to appropriate services in the most cost-effective manner possible; and

WHEREAS, access to Iowa's quality long-term living services could be improved by increased unification of the administration of these services; NOW THEREFORE,

BE IT RESOLVED BY THE SENATE, THE HOUSE OF REPRESENTATIVES CONCURRING, That the leadership of the senate and the house of representatives is requested to establish a blue ribbon planning group to develop a plan for unifying the state administration of long-term living services utilized by older Iowans who are age 60 or older; and

BE IT FURTHER RESOLVED, That the plan developed should address options for implementing the

unification of the state administration through legislation, funding changes, or other appropriate means and should address the services paid for or provided to older Iowans by the departments of elder affairs, human services, and public health; and

BE IT FURTHER RESOLVED, That the departments that are the focus of the planning process are requested to provide information to the planning group and the legislative services agency is requested to provide staffing services to the planning group; and

BE IT FURTHER RESOLVED, That the unification plan should be presented to the general assembly upon completion, no later than April 1, 2005, and should be designed to achieve the following goals:

1. Provide for a more effective delivery of long-term living services to older Iowans.
2. Create financial efficiencies.
3. Increase accountability; and

BE IT FURTHER RESOLVED, That the appointments necessary for the planning group be made by the senate republican and democratic leaders and by the speaker of the house of representatives in consultation with the majority leader of the house of representatives and the minority leader of the house of representatives and that the membership of the planning group should include all of the following:

1. The directors of the three departments or the directors' designees.
2. A director of an area agency on aging.
3. A representative of the office of the governor.

4. A representative of the banking industry in this state who has significant experience with reorganization or restructuring of agencies.

5. The chief executive officer of a united way organization located in Iowa.

6. The president of an Iowa resource center for nonprofit organizations.

7. The president of the university of northern Iowa.

8. The chairman of the board of the largest private employer in the state.

9. An individual retired as president of the state's largest private health insurer who has served as mayor of Iowa's largest city.

10. The head of the AARP Iowa chapter.

11. The chief executive officer of an Iowa-based financial services company ranked by Fortune magazine as the sixth among life and health companies.

12. Two members of the senate and two members of the house of representatives.

Unification of Administrating Services for Older Towns.

THE CONSOLIDATION PROCESS

AGENCY RESTRUCTURING

By the end of 1996, the largest reengineering effort in the history of the New Jersey Department of Health was completed. Through the Executive Reorganization Plan (no. 001-1996), more than 20 programs and 600 staff members from four different state departments were consolidated into a single Division of Senior Services in the "new" New Jersey Department of Health and Senior Services (see Box 2). This new department was granted policy and budgetary authority to:

- Create new long-term care alternatives and oversee their quality through licensing and certification.
- Inform older adults and the people who care for them about their choices for care.
- Pay for senior services through Medicaid, the Older Americans Act, and all state funding dedicated to senior services.

By consolidating authority for policies, programs, and financing for long-term care for older adults, New Jersey joined a handful of states that concentrated on rebalancing such care. No state, New Jersey included, has combined all long-term care funding and functions for all populations into a single agency (Kane, Kane, and Ladd 1998). Oregon, Washington, Kansas, and Michigan have tried to integrate long-term care (Braunstein 2002; Kane, Kane, and Ladd 1998), using different methods. Unlike the other states, New Jersey now divides Medicaid financing responsibility between two cabinet-level departments, rather than creating one large "umbrella" agency.

BOX 2. PROGRAMS CONSOLIDATED INTO THE NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES IN 1996

From the Department of Health

- Development of regulatory standards and licensing of all facilities—nursing homes, assisted living, adult foster care, home health agencies, adult day care, etc.
- Planning for nursing homes—certificates of need
- Alzheimer's Day Care Program

From the Department of Community Affairs

- State Unit on Aging—the Division on Aging, with oversight of all area agencies on aging, Older Americans Act programs, Social Security block grant, etc.
- Office of the Ombudsman
- Office of the Public Guardian
- Adult Protective Services
- Congregate Housing Services Program

(continued)

From the Department of Insurance

- Senior Health Insurance Unit

From the Department of Human Services

- Nursing Facility Rate Policy and Reimbursement—rate setting, rate policy, claims, and provider support
- Nursing Facility Level Services—long-term care field offices, nursing facility preadmission screening, clinical audits
- Home- and Community-Based Services for Older Adults
- Statewide Respite Care Program
- Adult (Medical) Day Care
- Adult Social Day Care
- Home Care Expansion Program
- Community Care Program for the Elderly and Disabled (CCPED, which is a 1915(c) Medicaid waiver program)
- Pharmaceutical Assistance to the Aged and Disabled
- Lifeline Credit Program
- Tenants' Lifeline Assistance Program
- Hearing Aid Assistance to the Aged and Disabled
- Enrollment into the Medicare Savings Programs

ORGANIZATIONAL COMPLEXITIES

Consolidating authority for senior services was a complex process. In order to divide Medicaid budget and policy authority between NJDHSS and the New Jersey Department of Human Services (NJDHS), the two departments negotiated an interagency agreement, which was approved by the federal Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration). The federal government permits states to treat Medicaid more as a funding stream than as a functional program. States can divide responsibility for Medicaid between two or more agencies through several mechanisms. New Jersey chose to make NJDHS the "single state Medicaid agency" to coordinate the paperwork flow between the state and the federal government. Through an interagency agreement, NJDHS assures that all documents are completed in the form and process required by federal law. But NJDHSS has "the authority to establish the State's policy regarding care for its seniors," including budget authority over all Medicaid funds for senior services. In addition, the U.S. Administration on

Aging designated the new department as the single state agency for services provided under the Older Americans Act (NJDHSS 1997). Federal officials agreed to these changes after several high-level meetings.

Two aspects of this decision to split Medicaid policy and budget responsibility between two cabinet-level departments were particularly problematic. First, from an administrative perspective, the two departments needed to determine the most efficient way for NJDHSS to "subcontract" certain services that would be inefficient if split—services like information systems, claims processing, and fraud and abuse investigations. Second, from a policy perspective, the split between services for seniors and people with disabilities was sensitive. Which programs were primarily serving which group of people? The goals of policy and program consolidation might have been better served by consolidating both the Medicaid and state-only services for seniors and people with disabilities. But the governor's office had focused only on older adults. Without consulting people with disabilities, the governor's office determined that consolidation should be confined to senior services and programs. Since Oregon had first consolidated senior services and later included services for people with disabilities, the governor's office felt it would be prudent to begin with senior services and reevaluate the decision later. Several years later, Governor Whitman established an Office of Disability in the New Jersey Department of Human Services.

Although limited only to senior services, New Jersey policymakers agreed this consolidation was a good starting point to help many people who need long-term care find the information and services they need to make reasonable personal choices. The state legislature passed a resolution approving consolidation of senior services. The public concurred during regional meetings convened by area agencies on aging and their citizen advisory committees. The meetings stressed the need to help older adults and their families find information and assistance early enough to use their personal resources wisely and to find public support that would let them stay in their homes and communities whenever possible.

Reorganization of all senior services into one cabinet-level department appeared to raise the level of the policy debate about home- and community-based care for older adults and caregiver support for their families. The governor could now hold one department accountable for developing new programs and announce those programs county by county. She held roundtable discussions with older adults and their family caregivers and included their issues in her annual State of the State addresses to the legislature and the general public.

Organizational Cultures

Another major difficulty in consolidation was integrating staff from the Medicaid, Older Americans Act, public health, and survey-certification departments. Each group had its own perspective or organizational culture:

- The philosophy of the staff that administered the Older Americans Act was in many ways the strongest call to action. This staff believed that all older adults, regardless of income or frailty,

should have access to services that promote independence. They wanted to focus on older adults' ability to contribute to society as a whole. They wanted information and assistance for long-term care. But they also wanted information about employment, educational opportunities, and volunteer activities like reading to children.

- The staff from the Medicaid culture understood the public investment in long-term care and was vigilant about budget and accountability mechanisms to safeguard the public's trust.
- The public health staff members were "upstream" oriented. They wanted to promote self care, prevent disability, and restore function to all older adults, whatever the setting.
- The survey and certification staff continually spoke of quality. With the staff of the Ombudsman and the Public Guardian, they concentrated on the most vulnerable citizens who required protection by the state.

All these goals are noble. They also embody conflict. For example, it is not always possible to promote independence and protect people from the harm that can come from their own choices. It is very stimulating and important to hear discussions among survey staff and Ombudsman staff—who are mandated to protect public safety—and State Unit on Aging staff, who fiercely defend the older adult's right to make decisions, even when the decisions are rejected by families and neighbors. As staff members reflecting these varied perspectives came together, there were many debates and months of intense discussions. Those discussions shaped subsequent policies about adult foster care, assisted living, consumer-directed home care, health promotion, caregiver support, respite services, and adult protective services. The overriding mission—to promote independence, dignity, and choice for all older adults—helped to forge consensus. It was also helpful that the governor's office expected the staff to iron out differences internally and offer coherent policies and programs that would be embraced by the public and the legislature.

The best measure of this merger of philosophies and programs is the actual shift of long-term care from an almost exclusive investment in nursing homes to more home- and community-based options. The major question is whether reorganization helps achieve this goal. At a minimum, a rebalanced system helps people who would otherwise have entered an institution to receive care in the community instead; ideally, the system also supports people who are unlikely to need a nursing home but who do need services in order to remain at home.

Authority and Accountability

The policy rationale for consolidation is that it lets a governor hold one commissioner or secretary accountable for rebalancing. In most states, the authority and accountability for programs and budgets are diffused among three or more government agencies. Even states that have created a separate cabinet-level department of aging, like Pennsylvania and Maryland, do not grant these cabinet officials policy and budget authority for long-term care for seniors. The officials do not have authority over the nursing home budget. They do have administrative responsibility for "waiver"

programs that provide home care services to people who are eligible for nursing home care under Medicaid. But it is the Medicaid agency that has the final authority. This is very different from Oregon or New Jersey. In Oregon and New Jersey, the officially designated single state Medicaid agency processes the paperwork for the Centers for Medicare & Medicaid Services because other state agencies have the policy and budget authority over programs for older people and people with disabilities, not just "delegation" authority to administer programs on behalf of the single state agency.

It is difficult to shift funding among departments without clarifying the policy and budget authority vested in each department. Typically, the single state Medicaid agency feels that the aging agency does not respect its fiscal responsibilities and that the experts on aging will "give it all away." Conversely, the aging agency's experts think their Medicaid colleagues do not spend money creatively so that more people can live in their homes and communities. These competing voices make it difficult to advance a single, consistent, convincing argument for rebalancing long-term care. One goal of developing a consolidated department for senior services is to align the "creativity" of the aging community with the "accountability" of the Medicaid community. The governor finds both perspectives in one place. Those who advocate change have to deliver on the budget for change.