Ombudsman
LONG TERM CARE
RESIDENTS' ADVOCATE

Melanie S. McNeil, Esq.
State Ombudsman
J. Andrew Hales
Ombudsman Services Coordinator
Gabrielle Numair
Ombudsman Services Coordinator
Liang-Lin Chao
Ombudsman Services Coordinator
Tracey R. Williams
Ombudsman Program Consultant
Tina Lawrence
Administrative Assistant

February 29, 2012

Commissioner David Cook
Georgia Department of Community Health
2 Peachtree Street, N.W.
40th Floor
Atlanta, GA 30303

RE: Medicaid Redesign

Dear Commissioner Cook

As a part of the aging network serving individuals with disabilities, the Long-Term Care Ombudsman Program supports the Department of Community Health (DCH) efforts to improve outcomes for Medicaid members, utilizing resources as effectively as possible. However, Long-Term Care Ombudsmen (LTCO) caution that making changes to Medicaid for the Aged, Blind and Disabled (ABD) populations needs to be accomplished more slowly and incrementally than changes made for members served under the current care management (CMO) structure.

Required changes to Medicaid
Because care management was new to Georgia when implemented in 2005, it makes sense to take time in 2012 to reassess, revise and innovate for those who are currently managed by CMOs. Preparing for the addition of thousands more low income adults to the Medicaid roles in response to the federal mandate in the Affordable Care Act is a significant undertaking that will require adjustments to the current care management structure.

Now is the time to make changes to the existing program to prepare for the increased volume of members with similar needs to the existing care managed population. Now is the time to evaluate the priorities for improving health outcomes for members. Now is the time to consider efficiencies in utilizing health care and financial resources.

Optional changes to Medicaid

The Navigant report recommends including the ABD populations in managed care. The report does not provide sufficient details about how managed care would benefit Medicaid participants who make their homes in Skilled Nursing Facilities (SNFs), Personal Care Homes (PCHs) and other long-term care facilities. More coordination among acute care providers and providers of long-term services and supports such as primary care and specialist physicians, pharmacists, therapists, direct care workers, and social services providers could help Medicaid members in some instances improve their health and, in other instances, may slow the expected decline of the member's health. More coordination between payer sources including Medicare and Medicaid is a worthy goal, as well.

What the report fails to detail are the differing needs and the very diverse nature of ABD members and their health and social needs. We appreciate that some Medicaid members who are residents of long-term care facilities will be residents for a short time for rehabilitation and return to the community. Some who have been a SNF resident for years have hope to return to the community with supports through the Money Follows the Person (MFP) program. Some Medicaid members reside in a long-term care facility to manage the ongoing and active decline in the end of life process.

Furthermore, more and more long-term services and supports providers are implementing innovations in care through what has been termed Culture Change. Many facilities have embraced innovations such as consistent assignment of direct care workers, new techniques to reduce pressure ulcers and new approaches to pain management. These are examples of changes that facilities have adopted to improve health outcomes and control costs for residents – regardless of payment source.

LTCOs support the continuing development of Medicaid waiver programs to serve ABD participants to fulfill the promise of the United States Supreme Court *Olmstead* decision that individuals should be able to live in the least restrictive setting possible. Georgia has partnered with the federal Centers for Medicare and Medicaid Services (CMS) to move SNF residents out of SNFS with the MFP program. For SNF residents who express their desire to return to the community, LTCOs frequently assist through advocacy with the facility staff and with other partners in the aging network such as the Aging and Disability Resource Connection (ADRCs). ADRCs are a federally funded resource that serves as a single entry point to aging and disability services for individuals, whether they have the means to pay for long-term services and supports himself or herself, or they qualify for Medicaid to pay for the services. With the number of older adults increasing, LTCOs are aware that the need for options for facility care and community care will continue for years to come.

Current Resources

Many resources – public and private – have been invested to develop long-term services and supports in Georgia. Continued public-private partnerships, that develop these local providers and networks, does more than just meet the needs of Medicaid participants. Local networks mean jobs in local communities not just for health care providers, but for the entire community. Continuing to support the local nature of long-term services and supports offered in the community and in facilities keeps the decisions for care local, the providers of care local, and the dollars for care local. Taxpayers would support keeping their tax dollars in Georgia rather than tax dollars paying out of state corporations to manage care.

ABD populations are not homogenous

Not all older adults are blind, not all blind are otherwise disabled, and many individuals with disabilities are children and young adults. Those individuals included in ABD are not as similar as the children who are in the Medicaid program or PeachCare for Kids.

The needs of older adults are very different than the needs of a child with developmental disabilities or for a younger individual with profound physical disabilities. It is not appropriate to overlay one solution for such disparate needs. Changes to care for ABD participants should include a person centered approach recognizing the different needs of each individual whether they live in the community or in a long-term care facility.

Any change to management of ABD members must take into account the advantage of the current structure. What we know about frailer individuals like those in the ABD population is that significant changes can trigger decline in the member's health resulting in the need for more services and raising the costs of care. In addition, for ABD members the natural progression of the member's age or disability is a concern that does not exist in the low income Medicaid population whose members' health is often more stable and whose needs are more predictable.

The Navigant report does not make clear the different considerations among those on Medicaid waivers living in the community versus the needs and concerns with providing care to Medicaid members living in facilities. Before making changes to ABD, clear determination of the needs and the solutions for these different populations and the different settings must be identified.

Office of the State Long-Term Care Ombudsman
2 Peachtree St., N.W.
9th Floor (mail), 8th Floor (office)
Atlanta, GA 30303-3142
Phone (888) 454-LTCO (5826) FAX (404) 463-8384
www.georgiaombudsman.org

Recommendations

As the Department of Community Health (DCH) considers changes to Medicaid, the Office of the State Long-Term Care Ombudsman recommends the following:

1. Focus on determining, implementing and evaluating the changes for the Medicaid members currently managed by CMOs and those newly eligible members that are not part of ABD;
2. Delay making changes to ABD until after the changes above are completed and evaluated;
3. Determine the cost drivers for each group within ABD to determine what is currently working and should be continued versus what needs to be changed to improve health outcomes and reduce costs;
4. Develop and test evidence based changes to ABD using a pilot program format,
    a. testing the changes in both an urban and a rural setting, before rolling out broadly,
    b. making changes appropriate to the care setting, innovations for facility based care could be different than changes for community based care,
    c. develop innovations tailored to the specific populations to be served to assure each change will improve health outcomes for the differing populations that make up ABD membership;
5. Only after changes have been successfully piloted, deploy them using a phased in approach building in regular evaluations to assure successful deployment;
6. In developing pilot changes to ABD, include input from consumers and other stakeholders;
7. When appropriate, include Medicare in the innovations; and
8. Provide that members voluntarily participate.

The Medicaid program is truly the lifeline for so many Georgians. Please let us know what more we can do to participate in this process of evaluation and change.

Sincerely,

Melanie S. McNeil, Esq.
State Long-Term Care Ombudsman

Cc: Ann Williams, Long-Term Care Advisory Council Chair

Office of the State Long-Term Care Ombudsman
2 Peachtree St., N.W.
9th Floor (mail), 8th Floor (office)
Atlanta, GA 30303-3142
Phone (888) 454-LTCO (5826) FAX (404) 463-8384
www.georgiaombudsman.org