Issue Brief

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Rebalancing Georgia's Long-term Care System

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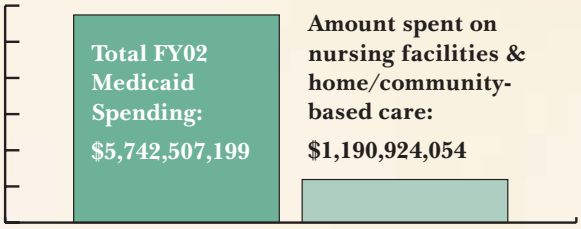
Georgia Medicaid spent just over $1 billion (almost 21 percent of total Medicaid payments) on nursing facility and home and community based (HCBS) long-term care services in fiscal year 2002 *(Figure 1)*. That amount could more than double in 20 years. The need to rebalance long-term care service delivery and financing systems is driven by the cost of institutional long-term care, the 1999 Supreme Court Olmstead decision, and the growing number of residents in need. How Georgia rebalances its long-term care system now may alleviate budget pressures in the near term and strengthen its ability to assist the growing number of aging residents in need of services.

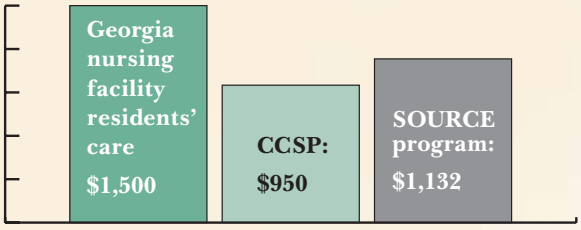
Figure 1



Cost

It is understood in the national research literature that institutional care - in most instances nursing facility care - is more expensive to provide than HCBS, which are commonly delivered to eligible individuals through Medicaid waiver programs. Research led by Dr. James P. Cooney Jr. and Glenn M. Landers at the Center for Health Services Research and the Georgia Health Policy Center, both at Georgia State University, demonstrates that the risk adjusted[I] total monthly Medicaid cost of Georgia nursing facility residents' care in 1999 averaged $1,500, compared with $950 and $1,132 for the Community Care Services Program (CCSP) and the SOURCE[II] program respectively *(Figure 2)*.

Figure 2

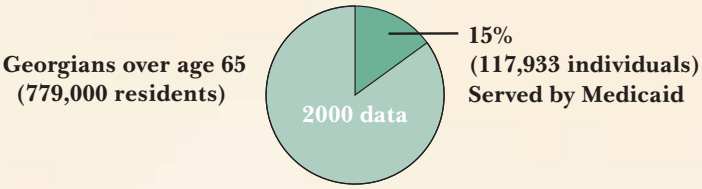


The Olmstead Decision

In 1999, the U.S. Supreme Court ruled in *L.C. & E.W. vs. Olmstead* that states must provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities. In addition to addressing transportation, housing, and education, states have responded to the ruling by making efforts to transition clients from institutionally based care to that which is provided in a homelike environment. To implement Olmstead, Georgia has taken advantage of several federal programs such as the Real Choices Systems Change, Nursing Facility Transitions, and Independence Plus grant programs.

Direct comparisons among states of institutional and HCBS services supported by Medicaid are not exact, but in FY02, Georgia Medicaid served 53,390 individuals in need of long-term care in nursing facilities[III] and 26,035 individuals in various Medicaid waiver services for HCBS. Oregon serves only 16 percent of its aged and physically disabled populations and just one percent of its developmentally disabled population in nursing facilities - the remainder is served at home or in substitute community care[IV]. Texas is experimenting with an option to let nursing facility residents move to a community environment - the money would follow their choice of care setting.

Figure 3



The Baby Boom Generation

Georgians over age 65 account for approximately 9.6 percent of the total population, or about 779,000 residents. Georgia Medicaid served 15 percent of that figure, or about 117,933 individuals, in 2002 *(Figure 3)*. By 2025, the percent of Georgians over age 65 is expected to be 17 percent - an increase of 77 percent. All else being equal, Georgia Medicaid could be serving 251,660 individuals over age 65 by 2025, and most will be in need of long-term care services.

Actions: What Georgia Can Do

An essential step in rebalancing Georgia's long-term care infrastructure (in order to achieve potential cost savings, meet the requirements of the Olmstead decision, and accommodate greater numbers of individuals over the age of 65) is to match patients to appropriate services in the least restrictive setting. Other states provide a roadmap for policy initiatives that Georgia may wish to pursue as it grapples with how to maintain fiscal responsibility while accommodating all of those who need services.

Creating a Common Method of Assessment for Long-term Care Services

States have shown that creating a common method of assessment for long-term care services improves the matching of patients to appropriate services and maximizes the benefits of existing care options. Maine enacted a common method of assessment system in 1998. Conceptual work on such an information system was completed for Georgia Medicaid by the Georgia Health Policy Center in 1999. Existing, regional infrastructure could be built upon to create a comprehensive assessment system without having to build a stand-alone system.

Coordinating Funding for State Financed Long-term Care Services

States have streamlined the long-term care assessment and placement processes by consolidating all state financed long-term care programs into one agency. In Georgia, the SOURCE program is operated by the state Medicaid agency, while the CCSP program is financed by Medicaid but operated by the Aging Services Division of the Department of Human Resources (DHR.) Additionally, DHR administers the Older Americans Act for Georgia, offers HCBS services not covered by Medicaid, and operates an older adult wellness program and the Long-term Care Ombudsman Program. Washington State consolidated all of its long-term care policy, financing, and management functions into the Aging and Disability Services Administration and says that it has improved coordination of financing with federal programs and placement of individuals in need of services. States that have implemented programs that either fully or partially integrate Medicare and Medicaid reimbursement include Minnesota, Wisconsin, Massachusetts, Texas, Arizona, New York, and Florida.

Shifting the Balance of Long-term Care Services from Institutional to Community-based Settings

Georgia will always need an adequate supply of nursing facility beds for those truly in need of institutional care, but research has shown that some nursing facility residents can thrive in a homelike environment. Several states have enacted new bed moratoria and shifted funding to Medicaid waiver programs to maximize the use of community care. Washington includes community care in its nursing facility "bed need" equation for Certificate of Need applications, and Maine created a "bed bank" in addition to de-licensing nursing facility beds, achieving a reduction in institutional reimbursement of 16 percent in seven years.

States have also assisted in infrastructure development so that communities can build the direct care workforce necessary to serve individuals in their homes – an opportunity particularly relevant to Georgia's rural counties. Georgia has already invested substantially in strengthening community-based health networks. Those same networks might provide the platform from which to develop a strong direct care workforce.

Conclusion

Georgia is not unique in its need to rebalance the delivery of Medicaid financed long-term care services. In fact, Georgia's Medicaid budget is stronger than many other states - particularly in the southeast. However, Georgia has not yet achieved the transformation of financing and delivery systems necessary to accommodate financial, judicial, and demographic realities. Beginning that transformation now will position the state to be a responsible steward of taxpayer dollars and to achieve its mission of improved health for all Georgians.

[I] Risk adjustment takes into account patient variation (diagnoses, gender, age, disability status, race, rural residence, rehabilitation status, and survival status) in order to isolate program effects.

[II] Service Options Using Resources in a Community Environment (SOURCE) is a community based long-term care program that incorporates primary care physician oversight and enhanced case management into the delivery model to improve outcomes

[III] Not including swing beds.

[IV] J. Toews, "Maintaining a Comprehensive Long-Term Care System Challenged by Severe Budget Reductions," presented at the National Academy for State Health Policy Annual Meeting, Portland Oregon, August 2003.