2005 REPORT ON MEDICAID REBALANCING ACTIVITY
Compiled By
NAHC/Forum of State Associations

Medicaid “Rebalancing” is a term given to the restructuring of the Medicaid care delivery and reimbursement systems. This “Rebalancing” report takes a snap shot look at Legislative and Administrative activities on a State by State basis. Information has been provided by individual State Home Care Associations and compiled by NAHC Staff.

Colorado
In Colorado, there is a big push to move young disabled from their nursing home "imprisonment" to community based setting. The disability community would prefer all community based care to be consumer directed, in one form or another, rather than the horrific "imprisonment" by the home care agency model. No one really wants to go to nursing home, so nursing home census has decreased by about 10% within 2 years. Money is not following to community based care. Statutory mandatory annual nursing home rate increases keep eating up long term care dollars with more than 25% of the state's budget used by Medicaid (big problem for other state services). The university system is the big loser which makes people mad who have children starting college with huge tuition increases. Home care, hospitals and physicians got 2% rate increase for 2005-06, while nursing homes got 6 - 9% annual increase.

Home care is at every table in Colorado but as long as nursing homes have mandatory off the top cost of living increases, there will never be enough $ left to adequately fund home care services. Bills to change this have been written in last two years, but never make it out of discussion stages due to nursing home lobby and huge campaign kitty. I'm talking thousands to each 100 legislator. In addition, consumer directed care overhead is being largely financed by federal grants (Supreme Court and Bush Admin). Makes it appear that consumer directed is both saving money and preferred by clients (of course only surveying those who choose it).

This summer all long term care providers will sit once again and try to develop an equitable reimbursement system. And we'll try a project called "integrated care" where dollars follow the person based on their need (novel idea don't you think!!) Reimbursement rates could go up for home care and assisted living; down for nursing homes; Time will tell.

Michigan
In particular, I would draw your attention to the Executive Order issued last week by Michigan Governor Jennifer Granholm. The full report of the Governor’s Medicaid Long Term Care Task Force is also available on this website. The Task Force just completed a year’s work in which we were significantly invested.

Governor Granholm promptly issued the Executive Order to implement its central recommendations. Principally, the recommendations and the Executive Order seek to rebalance Michigan’s long term care system with a focus on consumer choice and ready access to home and community-based services. The Executive Order establishes an Office of Long Term Care Services and Supports in the Michigan Department of Community Health. It also creates a consumer-driven Commission of the same name.

A key feature of the reform plan is a single point of entry system at which consumers will be assessed to determine their care needs and receive authorization to access services in the most appropriate setting of their choice. Essential to this system is a companion feature providing that funding streams will follow the client. The Executive Order establishes three single point of entry demonstration pilots, to be followed by statewide implementation once the pilot experience has been documented.

Again, the report of the Task Force and the Executive Order, as well as other related information, is available on the website and links identified below. www.ihcs.msu.edu/LTC/
**South Carolina**
Medicaid Choice (SCMC) brings an innovative concept and tool to move Medicaid beneficiaries into the health care market as vested consumers. Currently, Medicaid beneficiaries can “use” the services covered by Medicaid by going to a provider that agrees to serve them. Except for the very limited participation in Managed Care Organizations in South Carolina, providers do not market to beneficiaries. Providers market themselves to the Medicaid Administering Agency and to the State Legislature to get their services covered and to get their rates raised. Neither of these parties should be entering into the economic relationship between a provider and patient. Essentially, the State Agencies are assuming the role of an employer (providing a description of the desired plan and contribution of funds for coverage) in the typical insurance-based model of health care.

To change the dynamics of the relationship among the state, the beneficiary, and the provider, SC DHHS, through the SCMC waiver, will vest the beneficiary with buying power. Each beneficiary will be given a Personal Health Account (PHA) to pay for part of their health care expenses and exercise their power as a consumer of goods and services. The account will be funded with an actuarially determined amount generally based on current fee-for-service average expenses and will be risk adjusted. It is expected that the account will be available on an individual basis. Each qualifying beneficiary will be required to use the account to purchase a benefit coverage plan from an array of options approved by the agency. These coverage options will range from a safety net of limited benefits to full service plans. This range of plans provides a broad continuum of consumer flexibility ranging from Managed Care Organizations (MCOs) to Self-Directed Plans.

**Kentucky**
We had a resolution passed during our winter 2005 legislative session - mostly concept nothing specific for reimbursement. The first proposal looked verbatim from federal initiatives. There was a great outcry from both consumer based and nursing home folks. Resolution was rewritten and ultimately was passed. Nursing Homes and institutional MRDD groups are still very concerned. There really are no details about how they will actually alter reimbursement.

A broad based consumer oriented coalition is strongly supportive. This coalition has some providers but only the home and community based providers. Our association is very much a part of this group. This coalition has a lot of strength and recognition among legislators and also now the Medicaid officials because it was successful in efforts to correct some disastrous policy changes that cut 3000 persons from the waiver services despite the state officials saying that it would be nursing home residents that take the hit. A law suit was filed by Legal Services with support from the Coalition and won! After we spent 6 months speaking at hearings and telling legislators about the gaps and fallacies in the policies, they finally realized we knew what we were talking about so the group carries a lot of credibility now.

As one of the few provider groups involved we have chosen to be the source of fact and details on how programs work & the holes but let the consumers be out front about the impact on individuals.

**Florida**
The re-balancing is simple here. Bid the entire program to private insurance plans that will design basic and catastrophic benefit packages (within as yet unspecified state-set parameters) who will then run the program from start to finish with the state role reduced to paying monthly premiums to these plans for Medicaid enrollees and supplying some unspecified level of oversight.
North Dakota
Rebalancing Initiative/ Real Choice Systems Change Grant funded by CMS and awarded to the North Dakota Department of Human Services- Aging Services.
The focus of this grant is to provide choice and self-directed community resource delivery for the elderly and people with disabilities in North Dakota. The Real Choice grants provide funding to build infrastructure that will result in effective and enduring improvements in community long-term support systems.

As President of our ND Association for Home Care, I was asked to represent home care on the steering committee. We have roughly 30 members on the Steering committee and have had two working meetings so far with future meeting scheduled for every other month for the next 2 ½ years. We are developing a stake-holders committee list of representatives from a vast array of state, community and private agencies as well as legislators, the Governor's Office and consumers interested in this initiative. All members of the Steering committee will also be on the Stakeholders committee. We have started to develop focus group questions and process. We will have two types of focus groups: consumers and HCSS providers. We are looking at utilizing focus group meetings, outreach surveys and one-on-one in home surveys.

It will be very beneficial to share what each of our states is doing in regard to these rebalancing projects.

Louisiana
Governor Kathleen Babineaux Blanco had already called for a Health Care Reform Summit here in our state, prior to the NGA initiative on rebalancing long term care. She made the rebalancing effort the first of six major areas of reform, bringing in experts from think-tanks, universities, and nationally recognized organizations to guide our state through the process. Many of the initiatives were addressed in the 2005 Legislative session, which ends today, Thursday, 6/23/05.

*Licensing* – Transfers licensing authority for providers of long term care services (personal care attendant, supervised independent living, adult day care, family support services and respite) from Department of Social Services to the Health Standards Section within Department of Health and Hospitals.

*Direct service workers* – Legislation passed this month will permit direct support workers, in limited settings, to perform selected health care tasks with oversight and training by a registered nurse. It insures the safe delivery of health care services from trained direct service workers to the elderly and those with disabilities receiving services in their homes and in the community. Rulemaking will commence shortly and our home care association will be involved.

*Registry for Direct Service Workers* – Create a registry for direct service workers in home and community-based settings to address concerns about patient safety in developing options for home and community care. The registry will include confirmation of required training and completion of a background check. The law is designed to prevent workers that have been convicted of abuse, neglect or exploitation or for whom DHH has investigated and substantiated charges from continuing to work. The registry will be accessible by consumers. The law passed June 6 and is awaiting the Governor’s signature.

*Office for elderly long term care services (Resolution)* – Directs DHH to plan for implementing an office under the Secretary that has full responsibility for programs and budgets that impact long-term care and the elderly. This consolidates a number of different departments and would facilitate directing and account for spending in long term care. This office would coordinate long-term care services affecting our elderly citizens in the most effective and efficient manner possible. There will be no new positions or additional resources. This will involve streamlining current resources and dedicating those resources to long term services for the elderly that is at the highest level of administration within DHH.

New Jersey
The NJ Legislature has introduced a rebalancing bill - the "Independence, Dignity and Choice in Long-Term Care Act" (A3956) and it is at [www.njleg.state.nj.us/2004/Bills/A3500/3956_11.HTM](http://www.njleg.state.nj.us/2004/Bills/A3500/3956_11.HTM). The AARP in New Jersey has been the primary driving force to achieve this legislation. The bill would "redirect LTC away from an over-reliance on institutional care toward more home and community-based options" by
redirecting Medicaid funds through reduction in those funds to nursing homes (based on nursing home clients discharged to home/ c-b care in a given year and number of nursing home beds vacated during the fiscal year). Those funds would be reallocated to home and community-based care, and expended solely for that care.

It also includes details as to prioritizing clients eligible for those redirected funds, provides for an expedited Medicaid authorization process for people needing home and community-based care, and establish an advisory group limited to designated legislative seats and policy spokespeople (neither providers, nor consumers).

Finally, the state is to (1) develop a system of LTC service coordination which minimizes administrative cost, improves access, and minimizes obstacles to delivery of that care; (2) identify home and community-based models which are efficient and cost-effective alternatives; (3) develop and implement a comprehensive consumer assessment system; and (4) develop and implement a comprehensive quality assurance system.

A final note: budget neutrality is also expected in this process - "No further expenditure of funds than would have been the case had the bill not been enacted".

B. CONSUMER-DIRECTED CARE IN NEW JERSEY
NJ has an RWJ Foundation "Cash and Counseling" grant program and it has successfully served a limited number of the disabled, and a very small population of Medicaid elderly clients. The choice was up to the clients in the Medicaid Personal Care Program, and most of the elderly chose not to use the program. Thus, the majority of elderly Medicaid clients receive home care via licensed agencies and their certified home health aide employees in New Jersey. The consumer-directed care option will continue to be available, but as yet it continues to be used on this limited basis - primarily by the younger disabled. It is not specifically mandated within the rebalancing legislation. At present, that legislation is open to all community care options - which is what our AARP-NJ prefers.

Maryland/DC
There is no discussion either in legislation or through regulations to rebalance from institutional to homecare. In Maryland, we are heavily Medicaid managed care -- maybe that's a reason why? For Maryland, there is significant discussion to eliminate our CoN beginning next year, and another group to restructure our homecare licensure regulations for 2007. So that is keeping us busy.

Minnesota
In the past 5 years Minnesota has begun the work of transforming an out-dated and unsustainable long-term care system. This system is based on the notion that long-term care is either passively custodial in nature OR that it is like medical care and can be provided in brief, episodic interactions. But growing prevalence of multiple chronic illnesses is testing these assumptions, giving rise to new ways to better manage multiple chronic illness and improve quality of life over an extended range of abilities. In addition, the present system is heavily institutionalized, and the highly regulated environment requires that significant resources be spent on paperwork rather than direct health care/support.

At the state level, and with the aid of state waivers for federal programs, Minnesota has begun to "rebalance" its long-term care system by shifting public expenditures from institutional settings to supporting people in their own homes and communities. But as it is currently designed the fundamental system does not deliver what people want and need, nor is it a system we can afford in the future. In order to continue to make progress in Minnesota and to meet emerging population needs, we will need to make two changes at the national level: fundamentally redesign the basic benefit set to address the multiple chronic care needs of tomorrow's older population and to stress the kinds of interventions that help people help themselves; and to rethink funding strategies, including a re-assessment of public/private responsibility for long-term care.
Missouri
The Medicaid programs were dramatically cut, reduced and eliminated in the General Assembly ending last month. Most changes go into effect 7/1/05 or 8/28/05. Included in the changes were the elimination of all therapies (PT, OT, SP) and most DME. In addition Hospice was eliminated by statute (but funded at least for one additional year). The legislature also passed a bill setting up the Medicaid Reform Commission that is outlined below. The same bill sunsets the state Medicaid program in June of 2008. The commission is holding hearing starting this week.

208.014. 1. There is hereby established the "Medicaid Reform Commission". The commission shall have as its purpose the study and review of recommendations for reforms of the state Medicaid system. The commission shall consist of ten members:

(1) Five members of the House of Representatives appointed by the Speaker; and
(2) Five members of the Senate appointed by the Pro Tem.

No more than three members from each house shall be of the same political party. The directors of the department of social services, the department of health and senior services, and the department of mental health or the directors' designees shall serve as ex officio members of the commission.

The commission shall make recommendations in a report to the general assembly by January 1, 2006, on reforming, redesigning, and restructuring a new, innovative state Medicaid healthcare delivery system under Title XIX, Public Law 89-97, 1965, amendments to the federal Social Security Act (42 U.S.C. Section 30 et. seq. ) as amended, to replace the current state Medicaid system under Title XIX, Public Law 89-97, 1965, amendments to the federal Social Security Act (42 U.S.C. Section 30, et seq.), which shall sunset on June 30, 2008.

Oregon
Oregon has one of the most, if not the most progressive Home and Community Based Care waivers in the nation. (One waiver which our bureaucrats are extremely proud of) The waiver includes many programs for seniors and the disabled to access services and to direct their own care. There is no State legislation pending nor work currently on rebalancing LTC, but there is work planned to start discussions again with key players. We'll be at the table. I have included an excellent detailed report that describes Oregon's structure as well as my summary for those who want to read a shorter version. Oregon's Promising Practices in LTC Systems Reform

Washington
The State of Washington has long been trying to minimize nursing home care and maximize community-based care. That doesn't exclusively mean home health or home care agencies, however. The State is much more interested in promoting care through less expensive independent providers. The drivers are the State (Department of Social and Health Services), the union that represents the independent providers (SEIU), the disability community, and our state budget. HCAW and other provider groups are involved in some discussions, but we lack power, and we're seen as too expensive.

Hawaii
The state of Hawaii has no bills in review regarding Medicaid at this time. However, a major restructuring of the Medicaid waiver programs has been proposed. The state has submitted a proposal to CMS to change the existing waiver programs into a managed care program. The state currently has a program called Quest which insures low income families. The new program will also include the aged, blind, and disabled. The state will be contracting with 2-3 insurers to manage the program. They are hoping to have full approval from CMS in about 2-3 months. Implementation of the aged, blind, and disabled portion of the program is planned for July 2007.

Virginia
Currently there are no rebalancing discussions. One legislative study is due in October that may or may not impact our January legislative session.
Kansas
In Kansas, I think we are going backwards...unfortunately! The state spent years trying to lower nursing home expenditures, by using moratoriums, etc. They were successful...but did not put any of the savings toward supporting community services or HC expansion. We are still losing the small, rural agencies. In addition, a huge number of agencies will no longer serve Medicaid waivers due to the inadequate reimbursement. The Legislature is aware of the problem but, so far, have only increased rates for docs. Now the Kansas Supreme Court has ruled that the legislature must double its education budget by July 1. The legislature is in a special session now, and they are talking about massive cuts. Others are pushing for tax increases but that is not popular in our conservative state. It's not that HC isn't effective and popular...it's just that they don't want to pay the providers what it's worth. Consequently, I can't really say that rebalancing is happening here....at least not like we would like to see it.

Nebraska
In Nebraska the Legislature passed a Medicaid Reform bill. Initially it had some opposition among healthcare providers because the Governor was only going to appoint 2 people from the HHSS committee to oversee the plan. The final bill was changed to include a Medicaid Reform Advisory Council. I am going to provide a brief overview of the bill and also include the website information for the final bill if you need the detail of the bill. LB 709 - [www.unicam.state.ne.us/pdf/FINAL_LB709_1.pdf](http://www.unicam.state.ne.us/pdf/FINAL_LB709_1.pdf)

The bill provides legislative intent to enact policies to among other things, (1) reduce the growth of Medicaid spending, (2) ensure future sustainability of the medical assistance program for Nebraska residents, (3) reduce the number of persons who are dependent on medical assistance benefits, (4) establish priorities and ensure flexibility in the allocation of medical assistance benefits, and (5) provide alternatives to Medicaid eligibility for Nebraska residents.

LB 709 requires the Governor and the chair of the Health and Human Services Committee to designate one person to conduct negotiations with the federal Centers for Medicare and Medicaid Services for the development of a Medicaid reform plan for the State of Nebraska. A Medicaid Advisory Council will be established to consist of 5 persons appointed by the Governor and 5 persons appointed by the Chair of HHSS Committee of the Legislature. The council shall consist of health care providers, healthcare consumers and consumer advocates, business representatives, insurers, and elected officials. The council will meet monthly. Public input will be sought and at least on public meeting will be held.

A plan will be submitted to the Governor and the Legislature no later than December 1, 2005, and shall include recommendations for the development of Medicaid plan amendments and waivers and draft legislation necessary to support such plan.

In addition to the LB 709 we have been working with the state for the past year on consumer-directed care. The state received a Real Choice Systems grant for 600,000 over a three-year period. Our Association was asked to participate as part of the Advisory Council. Our May meeting was cancelled and I have a call in to the contact at the state for an update on the program. This grant is the same as the one that Marcia, from North Dakota mentioned in her email. I'm not sure if the funding will continue because President Bush proposed to cut the Real Choice Systems grants from the budget. My understanding is that the grant money would be cut immediately.

The state would not receive the full $600,000. As soon as I hear from the state I will provide you an update.

Montana
Montana is not doing a lot for rebalancing at this time. They did increase waiver slots, however, during our recent session--which should take care of most of the waiting list. The waiver recipients can be seen by HHAs if they have a skilled need. Montana's funds are heavily directed toward SNFs. In fact, their funding was increased this year, though mostly due to a provider tax (at their request) that gets federal match. They also received a direct care wage add-on, which no one else was able to participate in. At this time, nothing is on the horizon for any specific rebalancing efforts to benefit HH providers.
Massachusetts
There is a lot of talk and planning going on at present but nothing more than incremental movement. We did this year up the financial qualifying criteria for home and community based waiver to 300% of FPL – it had been much lower and added some new slots, but the elderly waiver is still very modest. Most of the community care dollars referenced in the chart you sent out go to our MR/DD waiver which is much, much larger and is almost all personal care. Interestingly as well the per person expenditure in the MR/DD waiver exceeds $30,000 whereas the elderly waiver “cap” is under $5,000. Our Governor has announced that “Community First” is the “official” policy of his administration, but admits at this point it’s a “philosophy” not a set of actions.

We are on a number of planning groups, but they rarely meet and the state officials seem to be unwilling to share a lot of their thinking. We expect things to happen at some point as Mass has both a System Change and an NGA pilot grant and they to date have published a lot of reports (the latest:
http://www.umassmed.edu/healthpolicy/uploads/TransformingLTS_Final.pdf)

There is some good waiver data at the back of this lengthy CMS report

Medicaid is in kind of a holding pattern, rates are not going up, but they have not been dropped. The state is actually looking to expand the number of persons covered as part of a very aggressive “health care coverage for all” effort, which even our Republican Gov is on board to some degree. The Gov has tried to reduce nursing home funding – put them on a biennial and instead of annual rate review- but the legislature keeps overriding anything like this - and nursing homes got a bed tax two years ago to assure funding stream.

New Mexico
In NM rebalancing is moving at a fast rate. I sit on the committee and have sat on the committee from the beginning. The Secretary of the Aging Department has hired three consultants to work on this for her. That is the best news because it is not department people who do not have the time. One of the contractors is a great facilitator, the other great at research outside of the state and one, Karen Wells, research in the state for authoring a statute and regulation related to long term care issues. I also serve on the Policy Advisory Committee for the Aging Department so I am positioned to sit on the committee for two reasons…as a PAC member and as a rep for home care and hospice. Self-Directed is in the discussion as well as home and community based services rather than institutional. There are other things going on in NM, also...a separate self-directed waiver, cash and counseling grant from RWJ and Real Choice infrastructure grant dollars…I serve on all those committees also. It is busy and the discussions are good but sometimes painful.

Ohio
The tremendous impact on the state of Ohio due to the increased cost of Medicaid has challenged the state to take action to decrease the rate of growth. In 2003 Ohio created a commission to evaluate the Medicaid program and make recommendations about reform and cost containment initiatives for this year’s budget, which was introduced January and became effective July 2005. You can view the Commission’s report at http://www.ohiomedicaidreform.com.

To address rebalancing the state approved several directives which included: 1) directing application for Medicaid waivers for the voucher program and the assisted living; modifying the Long-Term Care reimbursement formula; created an initiative to transfer people out of nursing homes to PASSPORT, required a certain segment of the Aged, Blind, and Disabled be enrolled in managed care, extended the exclusion timeframe that a person’s property be counted as a resource to determine Medicaid eligibility, co-pays on certain services (home care won exemption). Below is a detailed report listing these policy actions taken in the state’s Budget.
For Ohio the consumer choice waiver program cannot be considered “Rebalancing” except in the sense that it expanded participation of providers from home care agencies to individuals who obtained Medicaid Provider numbers. Both types of providers are paid the exact same rate, and until this month, Conditions of Participation (CoP’s) were non-existent for the individual providers. It is anticipated that the state plans to reconfigure this program and part of it will have aspects of the voucher program and consumer “directed” care. Which will be most likely be labeled as “rebalancing”.

Illinois
We passed legislation last year which is not a strict Medicaid rebalancing law, but a step in that direction. You can see it at: [www.ilga.gov/legislation/default.asp?ga=93](http://www.ilga.gov/legislation/default.asp?ga=93) then click on SB2880.

West Virginia
WV Medicaid has hired a consultant to begin the process of looking at rebalancing Medicaid. Sally Richardson was the Director of State Operations and Medicaid at HCFA 1993-1999. Since returning to West Virginia she has been the Executive Director of the Center for Healthcare Policy and Research through West Virginia University. Their office will be developing the recommendations for rebalancing Medicaid in WV. For more about the center go to, [http://www.wvhealthpolicy.org/index.html](http://www.wvhealthpolicy.org/index.html)

Another interesting note for WV Medicaid is the OIG’s recent release of an audit report showing WV owing 2.9 million in overpayments to CMS. WV is stating that they have all ready repaid 869,000 but the OIG is not in agreement with their calculations.

One of the most recently proposed manners for saving Medicaid dollars has also been to reduce the number of available slots in the Aged and Disabled Waiver, a program that all ready has a waiting list of over 900 persons. West Virginia only has two waivers available - A/D and MR/DD

New Hampshire
This is a link to the NH, DHHS page on “GraniteCare”, what they have dubbed their version of Medicaid Modernization. It includes a link to HB 691, the legislation passed this session to implement certain aspects of the plan. The bill includes a lengthy section that is really not germane to the issue, forming a mental health commission. [http://www.dhhs.nh.gov/DHHS/OCOM/GraniteCare/default.htm](http://www.dhhs.nh.gov/DHHS/OCOM/GraniteCare/default.htm)

The NH DHHS initiated planning activities in Spring 2004 to develop a Medicaid Modernization strategy. The plan was released last Fall, and was subjected to analyses by the NH Endowment for Health and the NH Center for Public Policy Studies. As expected, there are many concerns about the cost-saving goals and the potential impact on those in need of Medicaid supports. The original plan was far-reaching, addressing all aspects of the Medicaid program, but the initial focus has been on long-term care. What follows is a summary of the LTC components that have been the focus of legislative action this year.

1. **Single Point of Entry**

DHHS proposes to ultimately have all those seeking long-term care services—whether mental health, DD or elderly and adult disabled—apply for care through a process using a single assessment tool for both nursing home and community-based care. After significant opposition from the mental health and DD communities, the Department decided to start the transition with the elderly and adult disabled groups.

A new comprehensive assessment tool will be implemented for all nursing home and HCBC-ECI (home and community-based care for elderly and chronically ill waiver) applicants as of January 1, 2006. The tool is being adapted from the instrument used in Maine, and assessments will be conducted by RNs employed by the state or counties.
2. Personal Responsibility
The Legislature passed a number of changes to the Medicaid financial eligibility criteria this session. The changes include increasing the look-back period on transfer of assets; initiating the penalty period at the time of Medicaid application, rather than the date of the actual transfer of the assets; amending some asset recovery rules; and allowing purchasers of private long-term care insurance that meets certain coverage guidelines to be exempt from Medicaid asset limitations after private insurance has been exhausted. These aspects of the plan will require a waiver application, and our new governor, a Democrat who unseated the Republican governor who appointed the present Commissioner of DHHS, is expected to delay or refuse to sign off on the waiver. This has become a very partisan issue.

3. Emphasis on Community-Based Care
The plan is intended to shift the bias away from institutional care to community-based care. While this legislative intent was made clear, there was little actual change in fiscal (budget) commitment to realize this objective. There was some greater ability given to the Commissioner of DHHS to shift funding between the LTC line items (nursing home, mid-level/assisted living, and home care), but that power is subject to a number of reviews and legislative oversight. That raises the potential for the powerful private nursing home and county nursing home lobbyists to impede shifts in funds to home care.

Also, NH has been moving aggressively to increase the use of unlicensed consumer-directed care, so we don’t expect to see any meaningful increase in demand for home health services. DHHS has laid out as a 5-year goal to reduce the Medicaid nursing home population by one third and to more than double the HCBC caseload.

Connecticut
The prime accomplishment so far has been the enactment of legislation stating that the state's policy is for LTC to be provided in the least restrictive setting - a statement of philosophy now in statute. Here is a link to a report that will give you more than you ever need to know about CT's rebalancing direction; [http://www.cga.ct.gov/age/LTCPlan04FINAL.pdf](http://www.cga.ct.gov/age/LTCPlan04FINAL.pdf)

Georgia
This is Georgia's most recent effort to reduce the strain on our Medicaid budget. Our Department of Community Health (DCH) estimates that this privatization of Medicaid and Peach Care could save $60 million ($23 million of that, in state funds) during the current fiscal year and $200 million (about $75 million in state funds) during FY 2007. This privatization initiative effort by DCH to slow down the increase in the cost of Medicaid in Georgia has been in the workings for the past two years and apparently we are one of the last states to do this (no surprise there). HOWEVER, the Aged, Blind and Disabled populations are not included in this model and will remain in the current fee-for-service environment. But DCH is nearing completion of a procurement to allow two disease management companies to assist in managing the utilization of Medicaid by 100,000 current ABD members statewide. For detailed information on this privatization initiative, go to [www.dch.state.ga.us](http://www.dch.state.ga.us).