

## EXECUTIVE SUMMARY

Fundamental reform is needed in order to ensure the long-term fiscal sustainability of the Medicaid program. More than simply sustaining the program, the Commission believes that Medicaid can and must continue to provide quality care to promote the best possible health of all beneficiaries. Taken as a whole, the recommendations set forth in this report promote Medicaid's long-term fiscal sustainability, while also emphasizing quality of care. Key principles that must be part of this transformation include changing how beneficiaries partner with the Medicaid program by encouraging personal responsibility, promoting and rewarding healthy behaviors, and inviting greater participation of beneficiaries in health care decisions that affect them.

The following recommendations reflect the Commission's continuing support for state flexibility in the design and administration of the program. The unique characteristics of states suggest that a "one size fits all" approach to Medicaid is not appropriate. States have demonstrated success with innovative approaches to addressing the health care challenges they face and we believe that beneficiaries will be best served if states are given additional flexibility to innovate. In addition, barriers to replication in other states should be reduced for programs that have demonstrated success.

### **A. Long-Term Care**

The anticipated costs for long-term care services in this country threaten the future sustainability of the Medicaid program. Medicaid is currently the largest single source of funding for long-term care services nationally, covering nearly half of all long-term care expenditures.

**1. Public policy should promote individual responsibility and planning for long-term care needs.** Congress, federal agencies, and states should implement measures that encourage individual planning for long-term care, such as:

- Provide federal and state tax incentives to encourage individuals to purchase long-term care insurance. For example, there should be an allowance for early withdrawal of IRAs, or other federally-approved retirement accounts, for the purchase of long-term care insurance. Additionally health savings accounts should be expanded for use for long-term care expenditures. Lastly, participating in the Long-Term Care Partnership Program is an option for states to provide such incentives.
- Provide federal and state tax incentives to employers to offer long-term care insurance as an employee benefit.
- Provide tax deductions/tax credits to encourage those providing informal care (such as family members and friends) to continue in this effort.
- Promote the use of home equity by individuals to finance long-term care services needed to maintain the individual in his or her own residence and prevent or postpone Medicaid enrollment. Federal and state initiatives to support the development of home equity programs, such as reverse mortgages, should

increase consumer awareness and access, ensure consumer protections, and encourage industry innovation.

- Increase state participation in the federally-sponsored Long-Term Care Awareness Campaign to improve public education about the importance of individual planning for long-term care needs.

**2. Changes in Medicaid long-term care policy should reflect what most seniors and persons with disabilities say they want and need, which is to stay at home in their communities in the least restrictive or most integrated setting appropriate to their long-term care needs with nursing homes as a last resort.**

- New Medicaid policy should respect beneficiary preferences.
- States should explore and build on new long-term care options authorized by the Deficit Reduction Act of 2005. States should be encouraged to incorporate long-term care services within their Medicaid state plan that includes nursing facilities, personal care, respite care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and certain home health, adult day care and other services currently offered primarily under Home- and Community-Based Services (HCBS) waivers. In most cases, home- and community-based services are less expensive than institutional services and preferable to the beneficiary.
- States should expand use of the Cash and Counseling model.

**B. Benefit Design**

Since its inception Medicaid has operated as a state-designed program within broad federal guidelines. This flexibility has been critical for states to respond to the health insurance markets and population needs in their states. The Commission believes that further flexibility is necessary to foster continued innovation and improved program efficiency.

**1. States should be given greater flexibility to design Medicaid benefit packages to meet the needs of covered populations. This flexibility should include the authority to establish separate eligibility criteria for acute and preventive medical care services and for long-term care services and supports.**

**2. Federal Medicaid policy should promote partnerships between states and beneficiaries that emphasize beneficiary rights and responsibilities and reward beneficiaries who make prudent purchasing, resource-utilization, and lifestyle decisions.**

**3. States should have the flexibility to replicate demonstrations that have operated successfully for at least two years in other states, using an abbreviated waiver application process. Waiver applications to replicate such demonstration programs should be automatically approved 90 days after the date of application unless the application does not meet the replication criteria.**

### **C. Eligibility**

The categorical nature of Medicaid eligibility has created a complex patchwork of coverage for targeted groups of individuals.

**1. Medicaid eligibility should be simplified by permitting states to streamline eligibility categories without a waiver, provided it is cost-neutral to the federal government.**

### **D. Health Information Technology**

As the largest purchaser of health care services in the nation, HHS is well-positioned to lead the Health Information Technology adoption effort and should continue to aggressively pursue policy and financing initiatives that will promote the implementation of interoperable health information technology, especially among state Medicaid programs and Medicaid health care providers.

**1. The Commission wants to emphasize the importance of investments in health information technology. The Commission, therefore, recommends that the budget scoring process utilized by the Congress amortize the cost of investments in health information technology over a period of five years, while also accounting for the long-term savings.**

**2. The Department of Health and Human Services should continue to promote and support the implementation of health information technology through policy and financing initiatives while ensuring interoperability.**

**3. All Medicaid beneficiaries should have an electronic health record by 2012.**

**4. State Medicaid agencies shall be required in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it shall adopt, where available, health information technology systems and products that meet recognized interoperability standards.**

### **E. Quality and Care Coordination**

The Commission believes that quality must be brought to the forefront of any discussion about reforming the Medicaid program. Our most vulnerable Medicaid beneficiaries need better care coordination and all Medicaid beneficiaries need a medical home.

**1. Federal law and regulations must be changed to require states to place all categories of Medicaid beneficiaries in a coordinated system of care premised on a medical home for each beneficiary, without imposing a burden on states to seek a waiver or any other form of federal approval.**

**2. The Commission recommends the following reform proposals to support the development and expansion of integrated care programs that would promote the development of a medical home and care coordination for dual eligible beneficiaries:**

- **State Plan Option.** Allow states to integrate acute and long-term care benefits/services for dual eligibles through Special Needs Plans (SNPs) or other mechanisms via the state plan.
- **Inclusive Participation.** Allow states to operate an integrated care management program that provides for “universal” (automatic) enrollment of dual eligibles with an opt-out provision, thus preserving beneficiary choice while allowing states to have a mechanism to improve the care and cost-effectiveness of care provided.
- **Streamline Medicaid and Medicare Rules/Regulations.** Identify opportunities to reduce administrative barriers to an integrated approach to care (e.g., marketing, enrollment, performance monitoring, quality reporting, rate setting/bidding, and grievances and appeals).
- **Dual Eligible Program.** Authorize states to implement, at their option, a new program for dual eligible beneficiaries, called *Medicaid Advantage*, that integrates Medicare and Medicaid benefits (e.g., primary, acute, behavioral, long-term care services and supports). *Medicaid Advantage* programs, modeled after the Medicare Advantage program, yet managed by the states, would provide a medical home and better coordinated care for dual eligible beneficiaries. *Medicaid Advantage* programs would also provide both the federal and state governments more predictability in budgeting for the significant portion of their Medicare and Medicaid spending on dual eligibles. The Federal government would continue to provide financial support for Medicare services through a risk-adjusted, capitated system of Medicare payments. States and the Federal government would continue to share the cost of the Medicaid portion of the benefit. Medicare Part D drug coverage would be integrated into the Medicaid Advantage plans. States or the plans they select could manage the full spectrum of services to provide an integrated care delivery program for dual eligible populations under streamlined rules and regulations. These plans would be close to the patient, collecting and evaluation treatment data, and states and the Federal government would monitor the plans to make sure obligations are being met. Plans would be required to provide core Medicaid and Medicare services, and patients would have the ability to opt-out. States would have the ability to create new incentives for quality.

**3. Medicaid should focus on purchasing quality health care outcomes for its beneficiaries rather than simply reimbursing for health care processes.**

**4. CMS should establish a National Health Care Innovations Program to 1) support the implementation of state-led, system-wide demonstrations in health care reform and 2) make data design specifications available to all other states for possible adoption.**

**5. State Medicaid agencies shall make available to beneficiaries the prices that they pay to contracted providers for common inpatient, outpatient and physician services.**

Remaining Challenges

While this Commission has accomplished much over the past 18 months, a number of issues have been identified that were deemed to be beyond the scope of our charter, but which cannot be ignored by policymakers who are considering Medicaid reform. The current federal-state financing arrangement and the procedure for determining the amount of federal dollars that flow to states using a formula for the Federal Medical Assistance Percentages or FMAP needs to be examined for possible reform. Additionally, the Commission acknowledges that access to affordable housing creates barriers to providing cost-effective home- and community-based health care for Medicaid beneficiaries.

The Commission was tasked with addressing the long-term sustainability of the Medicaid program. Taken together, our recommendations lay a solid foundation for fiscal sustainability, while also improving the efficiency and quality of care for Medicaid beneficiaries. Yet we recognize that Medicaid is only one part of a larger health care system and there are forces affecting that system that Medicaid, alone, cannot impact. We have laid the groundwork, but Congress, HHS and stakeholders, must continue the necessary work on our nation's overall health care challenges to chart a fiscally-responsible path to health insurance coverage for our nation.

## FOUNDATION FOR RECOMMENDATIONS

### The Context for Medicaid Reform

The Medicaid program has been reviewed for major reform periodically throughout its 40 year history. The current conversations about Medicaid reform are occurring as the program faces a host of challenges. Increasing Medicaid enrollment, and increases in health care costs generally have, put budgetary pressure on both the federal and state governments. Medicaid supports almost half of all long-term care expenditures nationally, and that share is expected to increase as the population ages. Compounding the problem is the fact that Medicaid has evolved as a complex program that addresses the health care needs of numerous and quite disparate populations. The program is an amalgamation of responses to different problems over 40 years, including the desire to: provide insurance to poverty-level children and pregnant women; provide insurance to otherwise uninsured people with disabilities; cover institutional long-term care in the absence of any other meaningful financing; shore up the finances for safety-net providers; subsidize the training of new physicians; and many others. Among the results of these sometimes competing priorities is a cumbersome categorical eligibility structure and diffuse coverage goals.

As indicated by the charge to the Commission, policymakers are concerned that the Medicaid program is unsustainable in the long-term without significant structural changes. It is important to remember, however, that many of the challenges facing the Medicaid program are symptoms of broader changes in the overall health care environment, a reduction in the percentage of working adults who receive insurance through their employers, insufficient private financing for long-term care services, and a large (and growing) number of uninsured. Medicaid and this Commission cannot solve these larger issues and until all areas of the health care system are engaged, certain challenges are likely to persist in Medicaid, in spite of the best efforts and intentions of this Commission, Congress or federal agencies.

The Medicaid program celebrated the 40 year anniversary of its enactment in 2005. Simultaneous with this milestone, the Commission was evaluating Medicaid's current role in providing health care services to specified populations, and assessing the appropriate role for Medicaid in the future. While the Deficit Reduction Act of 2005 (DRA) included some technical cost containment provisions and provided for an estimated \$28 billion in federal savings over ten years, the broader issue of the long-term sustainability of the program remains. The Commission realized an opportunity to consider reform proposals that could significantly impact the future and structure of the Medicaid program.

*Medicaid spending places significant budget pressure on federal and state governments.* Federal and state governments combined spent close to \$325 billion on Medicaid in fiscal year 2006. Medicaid spending is expected to reach over \$450 billion by 2011, and may

exceed \$600 billion by 2016. Medicaid is now the largest single category of state spending, surpassing elementary and secondary education.<sup>1</sup>

The Medicaid program has just experienced a period of significant growth. Medicaid enrollment increased by 36 percent from 1999-2004 and federal Medicaid spending increased by 64 percent over the same period.<sup>2</sup> One factor contributing to the increase in Medicaid enrollment was the recent recession, causing a loss of employment and private health insurance coverage. Medicaid prevented some of those who lost employer-sponsored insurance from becoming uninsured.<sup>3</sup> State level coverage expansions also contributed to the increase in enrollment and expenditures.

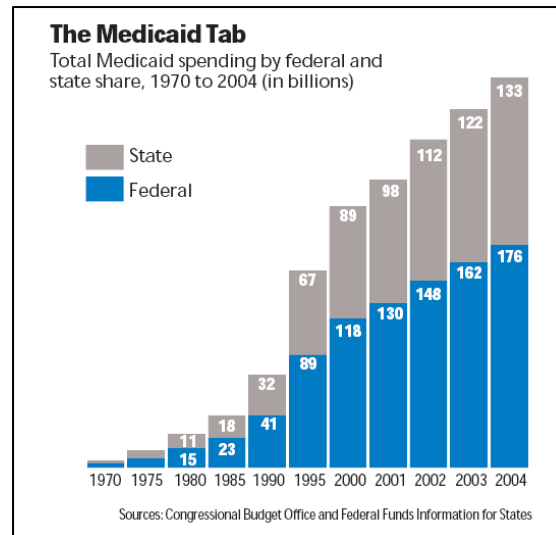


Figure 1. Source: Pew Center on the States, *Special Report on Medicaid: Bridging the Gap between Care and Costs*, January 2006.

While the economies in most states have rebounded from the severe deficits of the early part of this decade, and recent projections suggest that the rate of growth in spending is on the decline, Medicaid expenditures continue to be a concern for states and the federal government. Annual growth in Medicaid spending has fluctuated from a low of 3 percent to a high of 14 percent since 1997. While current estimates suggest that the annual growth rate is declining, an unanticipated change in the economy or the rate of health care inflation would have a substantial impact on Medicaid spending estimates. Also, short-term spending projections do not fully reflect the anticipated increase in the demand for long-term care services due to the aging of the U.S. population in the coming decades, nor do they account for the accelerating growth in Medicaid enrollment due to the migration of individuals from private employer-sponsored insurance coverage into Medicaid. Despite the short-term relief that Medicaid budgets may be experiencing, states and the federal government are likely to face budget pressure in the future unless the program undergoes major structural reform.

*Medicaid program spending is significantly impacted by economic factors.* Medicaid is an entitlement program with a defined benefit structure. As a result, individuals who meet the eligibility criteria typically are entitled to be covered, and once covered, they are entitled to all medically-necessary benefits the program offers. The dual nature of the

<sup>1</sup> National Governors Association and National Association of State Budget Officers, *The Fiscal Survey of States*, (Washington, D.C., June 2006).

<sup>2</sup> Congressional Budget Office, *Medicaid Spending Growth and Options for Controlling Costs*, Testimony before the Special Committee on Aging, United States Senate, July 13, 2006.

<sup>3</sup> Holahan, John, and Mindy Cohen, *Understanding Recent Changes in Medicaid Spending and Enrollment Growth Between 2000-2004*, Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family Foundation, May 2006).

entitlement – enrollment cannot be capped, and benefits cannot be capped, has led to a rapid increase in enrollment and overall expenditures. This dynamic is true even during lean budget years. As mentioned earlier, because Medicaid functions as a safety-net entitlement program, declining coverage in the private health insurance market during a recession can increase Medicaid enrollment and Medicaid costs at the very time public financing is in a recession. States are dually disadvantaged during a recession as they are forced to cover increasing costs with declining tax revenues, and the federal Medicaid matching formula is not structured to provide timely financial relief to the states. Although states recently have been given additional flexibility to design their Medicaid programs to control costs, economic factors continue to have a significant impact on Medicaid program spending.

*Although the Medicaid program operates as a safety-net program, its categorical eligibility structure leaves many low-income individuals without health insurance. The eligibility criteria for the Medicaid program have evolved over 40 years to meet discreet public policy goals. Originally intended to provide health care coverage to accompany*

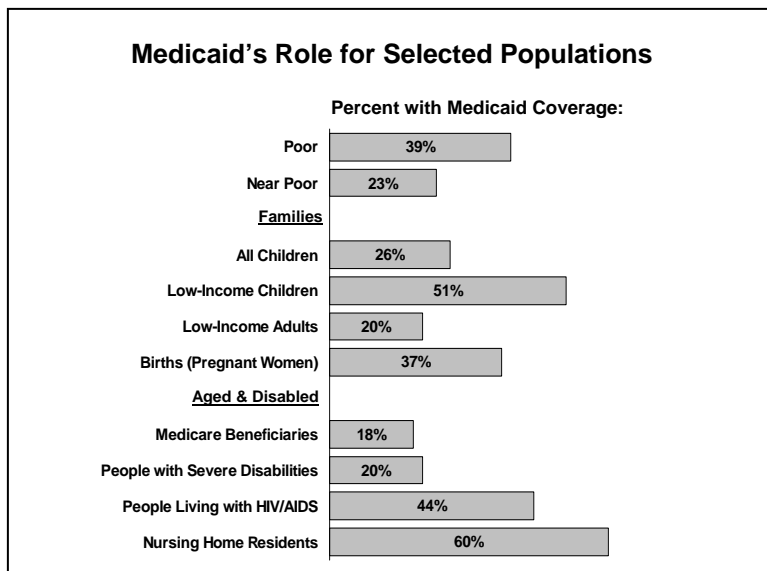


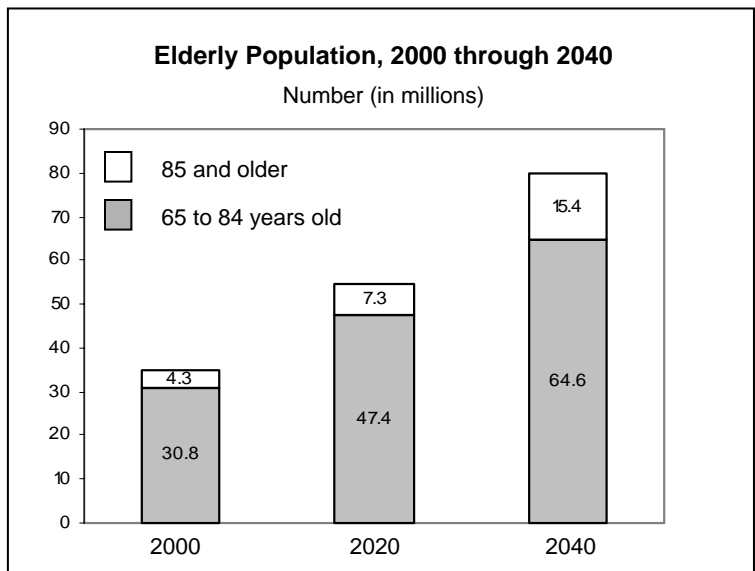
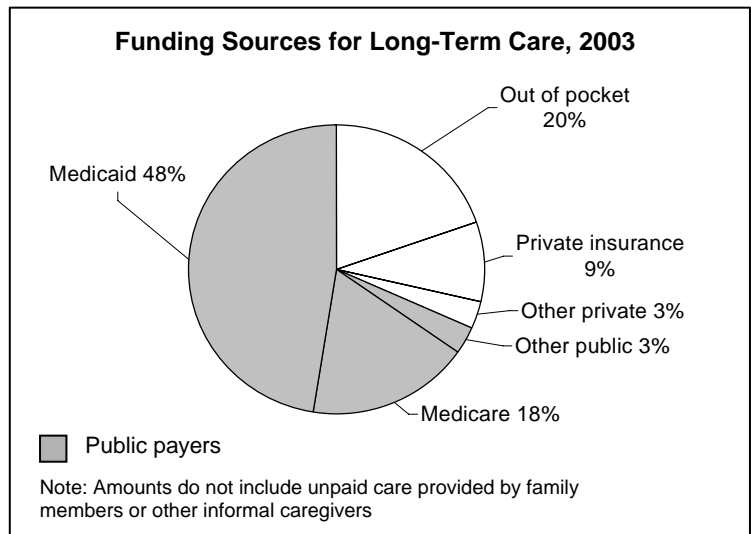
Figure 2. Source: Diane Rowland, Executive Director, Kaiser Commission on Medicaid and the Uninsured, and Executive Vice President, Kaiser Family Foundation, Testimony before the Medicaid Commission Jan 25, 2006.

poverty level. Although some states have pursued Medicaid waivers to expand coverage to previously uncovered populations, the extent of these expansions varies significantly. Despite state efforts, the U.S. Census Bureau recently reported the number of uninsured at 46.6 million in 2005, an increase of close to 7 million since 2000.<sup>4</sup>

cash welfare benefits, Medicaid has expanded over time to address gaps in coverage or meet the needs of specific groups (e.g., pregnant women). The result is a complex patchwork of coverage for targeted groups of individuals, primarily pregnant women, children and their parents, the elderly, and individuals with disabilities. Other low-income groups who do not fall into a targeted category, (e.g., adults between the ages of 21 and 64 without children, who are not blind, disabled, or pregnant), receive no coverage at all, even if they are far below the federal

<sup>4</sup> DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-231, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, (Washington, DC: U.S. Government Printing Office, 2006).

*The long-term sustainability of Medicaid depends upon significant changes in financing for long-term care services in this country.* Medicaid is the largest single source of funding for long-term care services nationally, covering nearly half of all long-term care expenditures, much of it for nursing home care. Close to two-thirds of nursing home residents rely on Medicaid as their primary source of funding.<sup>5</sup> The demand for long-term care services is expected to increase rapidly as the baby-boom generation approaches retirement age. Current projections suggest that aging populations are not sufficiently planning for potential future long-term care expenses. The sustainability of the Medicaid program will be severely compromised if Medicaid becomes the default funder of long-term care services for increasing numbers of middle income individuals who do not have sufficient resources or do not plan sufficiently in advance. As a result, policymakers are grappling with some key policy issues such as determining the appropriate role for government financing of long-term care services and examining what the government’s role is with regard to encouraging private financing of long-term care services.



Figures 3 and 4. Source: United States Government Accountability Office, Long-Term Care Financing - *Growing Demand and Cost of Services Are Straining Federal and State Budgets*, Testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 2005.

*The structure and financing of services for dual eligibles inhibits the effective coordination of services for this medically fragile and high-cost population.* There are an estimated 7.5 million dual eligibles simultaneously enrolled in Medicaid and Medicare. One-third of the dual

<sup>5</sup> O’Brien, Ellen, *Medicaid and Long-Term Care*, Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family Foundation, May 2004).

eligible population are individuals with disabilities under the age of 65, while two-thirds are low-income seniors. Although they represent only 14 percent of Medicaid enrollment, they account for 40 percent of Medicaid spending. Dual eligibles have lower incomes, more functional impairments, and are more likely to live in nursing homes than regular Medicare beneficiaries.<sup>6</sup> Health care expenditures for full benefit duals – those dual

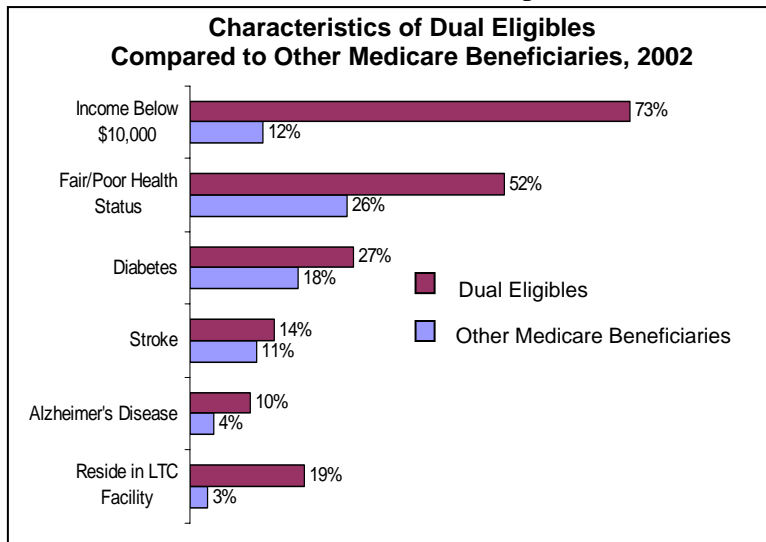


Figure 5. Source: Kaiser Family Foundation, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries*, July 2005

eligibles who qualify for full Medicaid benefits, are more than twice that for non-dual Medicare beneficiaries.<sup>7</sup> States have every incentive to coordinate care for this population. Yet the structure and financing of their services inhibits effective coordination. The Medicare program, administered by CMS, has primary responsibility for hospitalization, ambulatory care services, and, as of January 2006, prescription drugs. States, through the

Medicaid program, are responsible for most of the nursing home care and home- and community-based services provided to dual eligibles. This bifurcation of responsibility between the two programs promotes inefficiency and duplication of services. For example, states have little incentive to invest in innovative disease management programs that reduce hospitalizations for dual eligibles because they cannot share in the Medicare savings that such a program might generate. Clinical data is not shared between the two programs in an efficient and timely manner, inhibiting opportunities for either program to achieve effective care coordination. While the Medicare Modernization Act introduced Medicare Advantage Special Needs Plans as a platform for health plans to integrate Medicare and Medicaid funded services for dual eligibles who voluntarily enroll, there is not yet enough experience to effectively evaluate the success of these plans. Despite the fact that dual eligibles represent a low percentage of all Medicaid beneficiaries, their relatively high costs have made them a focus of many Medicaid reform proposals.

*Existing barriers impede the wide dissemination of information technology in health care.* It has been demonstrated that information technology has the potential to improve health care, in both quality and cost, in several areas, such as: reducing medical errors, improving compliance with clinical practice guidelines, and increasing efficiency by

<sup>6</sup> Holahan, John and Arunabh Ghosh, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003*, Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family Foundation, July 2005).

<sup>7</sup> Ryan, Jennifer and Nora Super, *Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?*, (Washington, D.C.: National Health Policy Forum, September 30, 2003).

avoiding service duplication. As the largest single purchaser of health care services in the nation, the Department of Health and Human Services is poised to lead the effort to foster the adoption of health information technology by its private and public sector partners. The Medicare and Medicaid programs combined spent \$600 billion in the U.S. health care system in 2006. As such, CMS is uniquely positioned to drive the development and implementation of common data standards and protections to facilitate appropriate communication of health information.

However, there are significant barriers to widespread dissemination of information technology in health care. Congressional efforts to increase federal financial support for the purchase and implementation of information technology have been hindered to date. The Congressional Budget Office scoring of such initiatives emphasizes the cost of implementation instead of the savings accrued as a result of program efficiencies that are likely to be achieved. Passing legislation that is scored as a substantial federal expenditure is difficult when there are competing interests for scarce federal dollars. Discussions about interoperability for health information exchange raise important privacy issues. While the dissemination of information technology to Medicaid-funded providers holds promise to improve efficiency and quality of care, policymakers must work through the barriers to achieve the desired results.

## RECOMMENDATIONS

Fundamental reform is needed in order to ensure the long-term sustainability of the Medicaid program. More than simply sustaining the program, the Commission believes that Medicaid can and must continue to provide quality care to promote the best possible health of all beneficiaries. Key principles believed to be part of this transformation include changing how beneficiaries partner with the Medicaid program: encouraging personal responsibility, promoting and rewarding healthy behaviors, and inviting greater participation of beneficiaries in health care decisions that affect them.

The Commission also believes that the health of beneficiaries will be improved through a more efficient Medicaid system that emphasizes prevention, provides long-term care services in the least restrictive appropriate environment, adopts interoperable forms of health information technology, coordinates care across providers and health care settings, and focuses on ensuring quality health care outcomes. The Commission feels strongly that as the Medicaid program serves America's most vulnerable populations, particular attention should be paid to reducing racial and ethnic health disparities. The Medicaid Commission recognizes the tremendous health care needs of the American Indian and Alaska Native populations. In recognition of this and their status as "dependent sovereign nations" we strongly encourage Congress to address these needs through passage of the Indian Health Care Improvement Act. Title IV of this Act contains Medicaid provisions addressing their needs as identified by the Indian Health Service and national Tribal Leadership.

The anticipated costs for long-term care services in this country threaten the future sustainability of the Medicaid program. Medicaid was never intended to become the primary source of funding for long-term care services in the country. Federal Agencies and Congress should take a careful and critical look at the long-term care system in our country and develop a fiscally sustainable plan for our nation's future long-term care needs in the coming decades. The Commission calls for an increase in personal planning for long-term care needs and an increase in private investment in long-term care financing; however, these incremental steps will not be enough to secure stable funding without placing significant budgetary pressure on government. Congress, federal agencies and states should take a systematic look at our nation's long-term care system as a whole, beyond Medicaid, to identify and evaluate opportunities for improving its sustainability in the coming decades.

The following recommendations also reflect the Commission's clear support for state flexibility. The Commission recognizes that the health care landscape varies widely across this nation and that, just as beneficiaries have different needs, so do states. States have demonstrated success with innovative approaches to addressing the health care challenges they face and they should be given additional flexibility to innovate.

## **A. Long-Term Care**

**1. Public policy should promote individual responsibility and planning for long-term care needs.** Congress, the Administration, and states should implement measures that encourage individual planning for long-term care, such as:

- Provide federal and state tax incentives to encourage individuals to purchase long-term care insurance. For example, there should be an allowance for early withdrawal of IRAs, or other federally-approved retirement accounts, for the purchase of long-term care insurance. Additionally health savings accounts should be expanded for use for long-term care expenditures. Lastly, participating in the Long-Term Care Partnership Program is an option for states to provide such incentives.
- Provide federal and state tax incentives to employers to offer long-term care insurance as an employee benefit.
- Provide tax deductions/tax credits to encourage those providing informal care (such as family members and friends) to continue in this effort.
- Promote the use of home equity by individuals to finance long-term care services needed to maintain the individual in his or her own residence and prevent or postpone Medicaid enrollment. Federal and state initiatives to support the development of home equity programs, such as reverse mortgages, should increase consumer awareness and access, ensure consumer protections, and encourage industry innovation.
- Increase state participation in the federally-sponsored Long-Term Care Awareness Campaign to improve public education about the importance of individual planning for long-term care needs.

As the largest single source of funding for long-term care services nationally, Medicaid covers nearly half of all long-term care expenditures. With the aging of the population, the demand for long-term care is only expected to increase. Congress and the Administration took initial steps toward addressing the challenges of long-term care financing with the changes to the Medicaid program contained in the Deficit Reduction Act of 2005 (DRA). The DRA closed several loopholes in the Medicaid eligibility rules to deter individuals from transferring assets to qualify for coverage, as recommended by this Commission in its first report. The DRA lifted the moratorium on the development of new Long Term Care Partnership Programs, permitting more state Medicaid programs to implement incentives for their state residents to purchase long-term care insurance. These changes were an important first step and building upon them is critical. Therefore, the Commission strongly urges Congress, the Administration, and states to aggressively pursue opportunities to engage alternative sources of funding to support the future long-term care needs of our aging population.

**2. Changes in Medicaid long-term care policy should reflect what most seniors and persons with disabilities say they want and need, which is to stay at home in their communities in the least restrictive or most integrated setting appropriate to their long-term care needs with nursing homes as a last resort.**

- New Medicaid policy should respect beneficiary preferences.
- States should explore and build on new long-term care options authorized by the Deficit Reduction Act of 2005. States should be encouraged to incorporate long-term care services within their Medicaid state plan that includes nursing facilities, personal care, respite care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and certain home health, adult day care and other services currently offered primarily under Home- and Community-Based Services (HCBS) waivers. In most cases home- and community-based services are less expensive than institutional services and preferable to the beneficiary.
- States should expand use of the Cash and Counseling model.

The DRA increased opportunities for states to expand beneficiary access to home- and community-based services without a waiver. The DRA also eliminated the waiver requirement for Cash and Counseling programs, which provide beneficiaries with individual budgets to control the acquisition and delivery of personal care or related services that support their needs in home- and community-based settings. The Commission strongly urges states to take advantage of the flexibility provided in the DRA to re-balance the provision of long-term care services and supports to beneficiaries and reduce the institutional bias of the Medicaid program. States should also expand models of self-direction such as Cash and Counseling programs allowing beneficiaries to have more control over their health care services. Medicaid policy should respect beneficiary preferences and seek cost-effective alternatives for delivering care that support beneficiaries in the least restrictive care setting appropriate to their needs.

## **B. Benefit Design**

**1. States should be given greater flexibility to design Medicaid benefit packages to meet the needs of covered populations. This flexibility should include the authority to separate eligibility for acute and preventive medical care services from eligibility for long-term care services and supports.** States should be given the authority to develop, without a waiver, separate benefit packages for separate populations, such as: (a) acute care and preventive benefits for low-income children and adults, (b) long-term care services and supports, and (c) premium assistance to encourage purchase of private insurance coverage in lieu of Medicaid benefits, or opportunities for working uninsured individuals to purchase a basic benefit package from a private insurer at an actuarially sound rate (on a cost-neutral basis for the federal government). Consistent with the benefit flexibility provisions included in the DRA, federal minimum standards requiring states to offer EPSDT coverage as a wrap-around benefit to populations under age 19 should be maintained.

With few exceptions, individuals who meet Medicaid's eligibility criteria are entitled to the full range of mandatory and optional benefits offered by each state, if they are medically necessary. The comprehensive nature of Medicaid benefits creates an entitlement to a range of benefits that far exceeds what most working Americans can access in the private market through employer-sponsored insurance or individually.

While those additional benefits play a key role in addressing the complex health care needs of many disabled and low-income Medicaid beneficiaries, not all beneficiaries need access to the full range of acute and long-term care services. By providing a benefit package that is more aligned with the needs of the population and more closely matches standard private market benefit packages, states can better control Medicaid expenditures and reduce incentives to substitute Medicaid coverage for private market insurance. Separating eligibility for acute care benefits from eligibility for long-term care benefits will give states more ability to regulate access to those services and therefore, to predict the budget for long-term care services and supports. The Commission is concerned about the number of uninsured individuals in the country, especially those who are working but unable to afford private coverage due to recent substantial increases in premium costs. States have demonstrated some success with offering premium assistance to Medicaid beneficiaries to purchase private health insurance and should be allowed to expand this option, or to provide uninsured persons access to basic benefit packages when meeting cost neutrality, without needing a waiver.

**2. Federal Medicaid policy should promote partnerships between states and beneficiaries that emphasize beneficiary rights and responsibilities and reward beneficiaries who make prudent purchasing, resource-utilization, and lifestyle decisions.**

States should have the authority to construct creative funding mechanisms to encourage wellness and prevention among beneficiaries and health plans and to promote beneficiary rights and responsibilities. Such mechanisms could include the creation of Medicaid Assistance Accounts, where beneficiaries earn financial credit for demonstrating healthy behaviors and can apply the funds toward co-pays, health insurance premiums, or payments for non-covered health care services. Healthy behaviors could include participating in disease management or wellness programs (e.g., diabetes management, weight reduction, and smoking cessation) and attending well-child appointments. States should also have the flexibility to offer cost-effective alternative benefits that promote wellness and disease/injury prevention (e.g., bicycle helmets) that have been shown to reduce the need for health services. States could also pursue defined-contribution models, placing the responsibility for health care dollars into the hands of beneficiaries to make health insurance purchasing decisions. While the DRA afforded states the flexibility to pursue some of these options for limited population groups, federal Medicaid policy should encourage states to expand these opportunities to engage beneficiaries as active participants in their health care.

**3. States should have the flexibility to replicate demonstrations that have operated successfully for at least two years in other states, using an abbreviated waiver application process. Waiver applications to replicate such demonstration programs should be automatically approved 90 days after the date of application unless the application does not meet the replication criteria.**

The current process for developing and approving a Medicaid waiver is resource intensive for both states and the federal government. The intent of waivers is to provide

states with the flexibility to demonstrate success in achieving a specified set of goals using innovations that are not regularly permitted by the program's regulations. States should be able to take advantage of "best practices" that have been demonstrated successful in other states. Therefore, CMS should develop an abbreviated waiver application process for states who want to replicate a successful waiver from another state.

### **C. Eligibility**

#### **1. Medicaid eligibility should be simplified by permitting states to streamline eligibility categories without a waiver, provided it is cost-neutral to the federal government.**

The nature of Medicaid eligibility has created a complex patchwork of coverage for targeted groups of individuals. Although Medicaid has expanded incrementally over time to address gaps in coverage or targeted needs (e.g., pregnant women), other low-income groups receive no coverage at all (e.g., adults between the ages of 21 and 64 without children, who are not blind, disabled, or pregnant), and over 46 million people remain uninsured. With at least 50 different eligibility groups, the Medicaid eligibility system is complicated for states to administer and confusing for beneficiaries. Therefore, the Commission recommends that states have the authority to simplify Medicaid eligibility by redefining eligibility groups without needing a waiver.

### **D. Health Information Technology**

#### **1. The Commission wants to emphasize the importance of investments in health information technology. The Commission, therefore, recommends that the budget scoring process utilized by the Congress amortize the cost of investments in health information technology over a period of five years, while also accounting for the long-term savings.**

The Institute of Medicine has documented the potential of health information technology to reduce medical errors and increase the efficiency and effectiveness of our health care system. Other industries have demonstrated how technology can improve productivity and efficiency and the health care industry must catch up. Congressional initiatives to support investment in health information technology are hampered, however, by the current budget scoring process. The Congressional Budget Office does not adequately capture proposed savings from increases in program efficiency when it scores health information technology legislation.

#### **2. The Department of Health and Human Services should continue to promote and support the implementation of health information technology through policy and financing initiatives while ensuring interoperability.**

The Department of Health and Human Services has several initiatives in place to encourage the dissemination of interoperable health information technology. Federal

health care programs have been ordered to implement health information technology systems and products that meet recognized interoperability standards and a recognized certification body has been designated. Recent rule changes now permit certain donations of interoperable electronic health record technology. An HHS advisory board has developed recommendations regarding standards for maintaining personal health records and managing disease outbreaks. The Commission believes that these efforts to establish industry standards must continue if our nation is to modernize its health system. As the largest purchaser of health care services in the nation, HHS is well-positioned to lead this effort and should continue to pursue policy and financing initiatives that will promote the implementation of interoperable health information technology, especially among state Medicaid programs and Medicaid health care providers.

### **3. All Medicaid beneficiaries should have an electronic health record by 2012.**

Medicaid beneficiaries should have electronic health records that can be accessed by any of their authorized providers in order to increase the efficiency and effectiveness of the health care rendered and reduce unnecessary duplication of services. A common electronic health platform that follows accepted privacy standards will ensure interoperability and provide for data exchange across all Medicaid providers.

### **4. State Medicaid agencies shall be required in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it shall adopt, where available, health information technology systems and products that meet recognized interoperability standards.**

This recommendation builds on the Executive Order signed by President Bush on August 22, 2006 calling for all federal health care programs “to promote quality and efficient delivery of health care through the use of health information technology...”, by extending the provision regarding the installation of interoperable health information technology by contractors (e.g., health plans, providers) to state Medicaid programs.

## **E. Quality and Care Coordination**

### **1. Federal law and regulations must be changed to require states to place all categories of Medicaid beneficiaries in a coordinated system of care premised on a medical home for each beneficiary, without imposing a burden on states to seek a waiver or any other form of federal approval.**

Coordinated systems of care that organize health care around a single medical home have been proven to improve quality and access. Federal barriers that impede the expansion of this successful model to all Medicaid beneficiaries must be removed and states should be required to implement models that link beneficiaries with medical homes. The Commission defines a medical home as a source of primary health care that provides accessible, comprehensive, coordinated care. Care should be delivered or directed by well-trained physicians who provide primary care services and who manage and facilitate

essentially all aspects of care. The primary health care provider should be made known to the beneficiary (and family, where appropriate) and should be able to develop a partnership of mutual responsibility and trust with the beneficiary.<sup>8</sup>

**2. The Commission recommends the following reform proposals to support the development and expansion of integrated care programs that would promote the development of a medical home and care coordination for dual eligible beneficiaries:**

- **State Plan Option.** Allow states to integrate acute and long-term care benefits/services for dual eligibles through Special Needs Plans (SNPs) or other mechanisms via the state plan.
- **Inclusive Participation.** Allow states to operate an integrated care management program that provides for “universal” (automatic) enrollment of dual eligibles with an opt-out provision, thus preserving beneficiary choice while allowing states to have a mechanism to improve the care and cost-effectiveness of care provided.
- **Streamline Medicaid and Medicare Rules/Regulations.** Identify opportunities to reduce administrative barriers to an integrated approach to care (e.g., marketing, enrollment, performance monitoring, quality reporting, rate setting/bidding, and grievances and appeals).
- **Dual Eligible Program.** Authorize states to implement, at their option, a new program for dual eligible beneficiaries, called Medicaid Advantage, that integrates Medicare and Medicaid benefits (e.g., primary, acute, behavioral, long-term care services and supports). *Medicaid Advantage* programs, modeled after the Medicare Advantage program, yet managed by the states, would provide a medical home and better coordinated care for dual eligible beneficiaries. *Medicaid Advantage* programs would also provide both the federal and state governments more predictability in budgeting for the significant portion of their Medicare and Medicaid spending on dual eligibles. The Federal government would continue to provide financial support for Medicare services through a risk-adjusted, capitated system of Medicare payments. States and the Federal government would continue to share the cost of the Medicaid portion of the benefit. Medicare Part D drug coverage would be integrated into the Medicaid Advantage plans. States or the plans they select could manage the full spectrum of services to provide an integrated care delivery program for dual eligible populations under streamlined rules and regulations. These plans would be close to the patient, collecting and evaluation treatment data, and states and the Federal government would monitor the plans to make sure obligations are being met. Plans would be required to provide core Medicaid and Medicare services, and patients would have the ability to opt-out. States would have the ability to create new incentives for quality.

Dual eligibles are a medically fragile and high-cost population. As such, both the Medicare and Medicaid programs have every incentive to effectively coordinate their care to avoid duplication of services and improve medical outcomes. The current program and financing structures, however, do not support the effective integration of care for dual eligibles. Existing regulations make it cumbersome for states to pursue

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<sup>8</sup> This definition is modeled after a July 2002 American Academy of Pediatrics Policy Statement.

integration and confusing for beneficiaries. The Commission believes that the barriers to integration should be removed so that states can design and implement programs to improve care coordination, reduce inefficiencies, and promote linkages with medical homes for dual eligibles. By providing a range of options, we give states the flexibility to identify and pursue the integration option that best meets their needs. Administrative barriers should not continue to impede Medicaid agency efforts to improve the quality of health care for this high-cost population through innovative care coordination initiatives.

**3. Medicaid should focus on purchasing quality health care outcomes for its beneficiaries rather than reimbursing for health care processes.** State Medicaid programs need to change their orientation from agencies that reimburse providers for performing individual health care processes to agencies that prudently purchase health care services from providers who deliver efficient and effective quality health care. This re-orientation requires states to develop methods for evaluating provider performance and encouraging innovative care coordination programs that focus on health outcomes rather than inputs. States and providers need to change the paradigm to providing care for the population, not the event.

Steps like ensuring that each Medicaid beneficiary has a medical home (Quality and Care Coordination Recommendation #1) will be instrumental in executing this transformation. State quality agendas could also include single- or multi-state demonstrations to evaluate quality and performance. Performance measures should have among their characteristics improved outcomes and lower costs to the overall health care system. States could also encourage the development and implementation of health information technology tools to improve care coordination and disease management both within and across health care settings. Real improvement will not occur until we focus on ways to deliver improved outcomes with the dollars following the care rather than the event.

**4. CMS should establish a National Health Care Innovations Program to 1) support the implementation of state-led, system-wide demonstrations in health care reform and 2) make data design specifications available to all other states for possible adoption.** The core objectives of these demonstrations would be to improve quality and control costs through the use of managed care approaches, chronic care/quality improvement programs, and health information technology. Such a program would continue to foster the state innovation that has yielded much success throughout the country.

**5. State Medicaid agencies shall make available to beneficiaries the prices that they pay to contracted providers for common inpatient, outpatient and physician services.**

In the spirit of the Executive Order signed by President Bush on August 22, 2006, calling for transparency of pricing information in federal health care programs, state Medicaid agencies should make price information available to beneficiaries to encourage prudent consumer purchasing decisions. By providing beneficiaries with price information, state Medicaid agencies engage them as responsible consumers, empowering them to be more prudent purchasers of services and to seek efficiency and value in the health care services they access.