Final Report and Recommendations

Medicaid Commission

Presented to Secretary Michael O. Leavitt
December 29, 2006

The Honorable Don Sundquist, Chair
The Honorable Angus King, Vice-Chair

Letter of Transmittal

December 29, 2006

To the Honorable Secretary Michael O. Leavitt:

On behalf of the Medicaid Commission, we are pleased to transmit to you the Commission's second and final report reflecting our recommendations for the future long-term sustainability of the Medicaid program. The delivery of this report, along with our report dated September 1, 2005, fulfills the Commission's mandate as reflected in the charter.

We would like to thank our fellow Commissioners for their dedication to this effort and commitment to improving the Medicaid program.

Sincerely,

Don Sundquist	Angus S. King, Jr.
The Honorable Don Sundquist Former Governor of Tennessee Founding Partner, Sundquist Anthony LLC	The Honorable Angus S. King, Jr. Former Governor of Maine Partner, Bernstein, Shur, Sawyer, & Nelson

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The Commission is grateful to the many experts whose presentations and publications provided guidance in shaping the recommendations contained in this report. We appreciate all those who gave generously of their time to attend our meetings and present suggestions for improving the effectiveness and sustainability of the Medicaid program.

We would like to acknowledge the efforts and contributions of the staff whose energy and diligence were instrumental in enabling the Commission to complete its tasks. We also thank Charles Milligan and Ann Volpel from the Center for Health Program Development and Management, University of Maryland, Baltimore County (UMBC) for assisting with the preparation of this final report.

We also acknowledge Michael J. O'Grady, Ph.D., former Assistant Secretary for Planning and Evaluation, and Donald A. Young, M.D., former Acting Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, who both served on the Commission during their tenures at the Department.

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 for 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 recognizing the long-term value of investments in quality, supporting state flexibility, and changing how beneficiaries partner with the Medicaid program by encouraging personal responsibility for health care decisions and promoting and rewarding healthy behaviors.

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. Finally, although the Commission recommends several incremental measures to encourage individual planning for long-term care, the Commission also calls upon federal agencies and Congress to develop a fiscally sustainable plan for our nation's future long-term care needs.

The following recommendations reflect the Commission's strong 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. The Commission's support for state flexibility is consistent with its recognition that Medicaid must remain a financial and administrative partnership between states and the federal government. In the Commission's view, the federal government should continue to have a vital role in ensuring that the Medicaid program delivers access to quality health care for the program's beneficiaries.

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, 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 a wider array of long-term care expenditures. Lastly, participating in the Long-Term Care Partnership Program is an option for states to provide such incentives.

- Provide new 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.
- The Commission recommends a study of policy options for using alternative insurance models for the provision of long-term care services. This study should include analyses of costs, revenue and governmental administration.

2. Changes in Medicaid long-term care policy should address institutional bias and 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 in a place they call home.

- 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, the Centers for Medicare and Medicaid Services (CMS), and Congress should be encouraged to utilize existing Medicaid resources to maintain and/or incorporate long-term care services within Medicaid State Plans that include nursing facilities, personal care, respite care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), home health, adult day services and other services currently offered in state plans and as Home- and Community-Based Services (HCBS). 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 and the flexibility with benefit design to allow states the

option to offer premium assistance to allow buy-in to job-based coverage or to purchase other private insurance.

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.

4. Compliance with existing regulations regarding the public notice and comment period about state proposals that would significantly restructure Medicaid (1115 waivers and state plan amendments) should be monitored and enforced.

C. Eligibility

The categorical nature of Medicaid eligibility has created a complex patchwork of coverage for targeted groups of individuals. Much money and effort are expended on the mere administration of Medicaid eligibility, which could be simplified. In addition, the Commission believes there are viable options for covering the uninsured other than public program expansion and encourages the United States Department of Health and Human Services (HHS) and Congress to consider other federal financing approaches to address this issue.

1. Medicaid eligibility should be simplified by permitting states to consolidate and/or redefine eligibility categories without a waiver, provided it is cost-neutral to the federal government.

2. The federal government should provide new options for the uninsured to obtain private health insurance through refundable tax credits or other targeted subsidies so they do not default into Medicaid.

3. Medicaid's core purpose is to serve needy low-income individuals, especially the most vulnerable populations. Therefore, the Commission recommends a study of a new "scaled match" funding formula in which the federal government would reimburse states at an enhanced matching rate for adding lower-income populations to the program, with the match rate scaling back as they expand Medicaid to higher-income populations. Fiscal implications, including cost neutrality, should be considered.

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. HHS should continue to aggressively 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 should include 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.

5. HHS, state Medicaid agencies, and their vendors shall assure that health information technologies that are acquired or upgraded continuously meet federal and state accessibility requirements.

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. States should place all categories of Medicaid beneficiaries in a coordinated system of care premised on a medical home for each beneficiary, without needing 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, while also providing necessary safeguards, 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 collect and evaluate 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.
- **Savings**. States and the federal government should share in savings for dual eligible members that are achieved through innovative care management strategies resulting in improved clinical and financial outcomes.

3. 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.

4. State Medicaid agencies shall make available to beneficiaries the payments they make to contracted providers for common inpatient, outpatient and physician services.

5. In order to pay for quality, states must first be able to measure it. Therefore, states should collect and mine data on how Medicaid money is being spent to determine which programs, providers, and services are effective and which need improvement. Payments to Medicaid providers then should be tied to objective measures of risk- and case-adjusted medical outcomes. This will lead Medicaid to become more patient focused, i.e., funding health care in a way that assures patients are getting the care they need.

6. CMS and Congress should support state innovation to deliver value for taxpayer dollars by purchasing quality health care outcomes as opposed to simply reimbursing for health care processes. The Commission, therefore, recommends that CMS and Congress provide enhanced match and/or demonstration funding, to be recouped from savings over a five-year period, to support upfront investments in quality improvement in targeted areas: development/enhancement of standardized performance measures, particularly for children, persons with disabilities, populations who experience disproportionate health disparities, and the frail elderly; implementation of care management programs targeted at high-risk, high-cost, co-morbid beneficiaries; and the creation of provider-level pay-for-performance programs.

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 open-ended federal-state financing arrangement and the procedure for determining the amount of federal dollars that flow to states using the formula for the Federal Medical Assistance Percentage (FMAP) should be examined in a comprehensive manner for possible reform. The more-limited study recommendation found in C.3 above may serve only as a precursor to more in depth analysis. Additionally, policymakers should examine whether the projected workforce supply is adequate to support our nation's health care delivery system, especially one with an increased focus on home- and community-based services. Finally, 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 given the task of 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 and HHS and stakeholders must continue the necessary work on our nation's overall health care challenges to chart a fiscally responsible path for providing health care to our nation.

Introduction

Purpose of the Commission

The Medicaid Commission was established by charter[1] by the Honorable Michael O. Leavitt, Secretary of the United States Department of Health and Human Services (HHS), in May 2005. The Commission charge is defined as follows:

a) The Commission shall report to the Secretary, for his consideration and submission to Congress, by September 1, 2005, their recommendations on options to achieve $10 billion in scorable Medicaid savings over 5 years while at the same time make progress toward meaningful longer-term program changes to better serve beneficiaries.
b) By December 31, 2006, the Commission shall submit to the Secretary a report making longer-term recommendations on the future of the Medicaid program that ensure the long-term sustainability of the program. They shall develop proposals that address the following issues:

    1) Eligibility, benefits design, and delivery;
    2) Expanding the number of people covered with quality care while recognizing budget constraints;
    3) Long term care;
    4) Quality of care, choice, and beneficiary satisfaction;
    5) Program administration; and
    6) Other topics that the Secretary may submit to the Commission.

The Work of the Commission

The Medicaid Commission held its inaugural meeting in July 2005. On September 1, 2005, the Commission delivered its first report to Secretary Leavitt and the United States Congress, describing recommendations on options to achieve $11 billion in scorable Medicaid savings over five years.[2] The Commission continued meeting from October 2005 through November 2006[3] to consider recommendations to promote the long-term sustainability of the Medicaid program and to develop this second report. Testimony was received from invited experts on all facets of the Medicaid program including eligibility, benefits, long-term care services, services for dual eligibles, quality, information technology, program administration, and financing.[4] Opportunity for public comment was provided at every meeting.[5]

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[1] A copy of the Commission's charter may be found in Appendix C.
[2] A copy of the Commission's first report may be found at http://aspe.hhs.gov/medicaid.
[3] A copy of the Commission's meeting schedule may be found in Appendix D.
[4] A list of individuals who made invited presentations to the Commission may be found in Appendix E.
[5] A list of individuals who personally testified in front of the Commission during public comment sessions may be found in Appendix F.

Background

The Medicaid Program

Medicaid is a means-tested health insurance entitlement program that provides medical and health-related services to certain categories of individuals, primarily pregnant women, children and their parents, the elderly, and individuals with disabilities. As the largest single health insurance program in the United States, Medicaid is expected to provide coverage for 53 million individuals at a cost of $350 billion in 2007. Originally enacted in 1965, Medicaid serves as a safety-net program for much of the nation’s most vulnerable populations. Medicaid provides coverage for approximately 25 percent of the nation’s children and funds over one-third of all births in the United States. Medicaid is also a significant source of coverage for people with disabilities and those who access long-term care services and supports. Over seven million low-income elderly and disabled dual eligibles rely on Medicaid to provide coverage for services that are not covered by Medicare.[6] Dual eligibles also receive help from Medicaid to pay Medicare premiums, deductibles, and co-payments.

The Medicaid program is jointly funded by the federal government and states. In some states, local governments support a percentage of the state’s share. The federal contribution varies by state according to a complex formula designed to give higher federal matching rates to states with lower per capita income, and vice versa. Nationally, the average federal share is 57 percent of expenditures. Federal support for individual states ranges from 50 to 76 percent of expenditures. In addition to funding direct services for Medicaid enrollees, federal Medicaid funding is directed to specific categories of safety-net providers including disproportionate share hospitals, federally qualified health centers, the Indian Health Service, and academic medical centers.

The Medicaid program is administered at the state level within federal guidelines. States are required to cover certain federally mandated populations and benefits, yet have the authority to expand coverage beyond those minimums. Because states have broad authority to design their Medicaid programs, eligibility criteria, benefit packages, and modes of service delivery vary significantly across the country. The federal government has not devolved complete control to the states, however. Significant changes to a state’s Medicaid program must be reviewed and approved by the Centers for Medicare and Medicaid Services (CMS), in part to ensure the fiscal integrity of federal dollars and to provide a measure of consumer protections.

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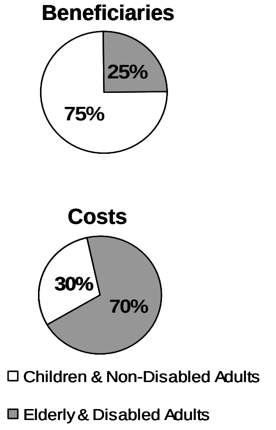
[6] A “dual eligible” is a person who qualifies for both Medicare and Medicaid.

Figure 1. Coverage versus Costs
FY 2005



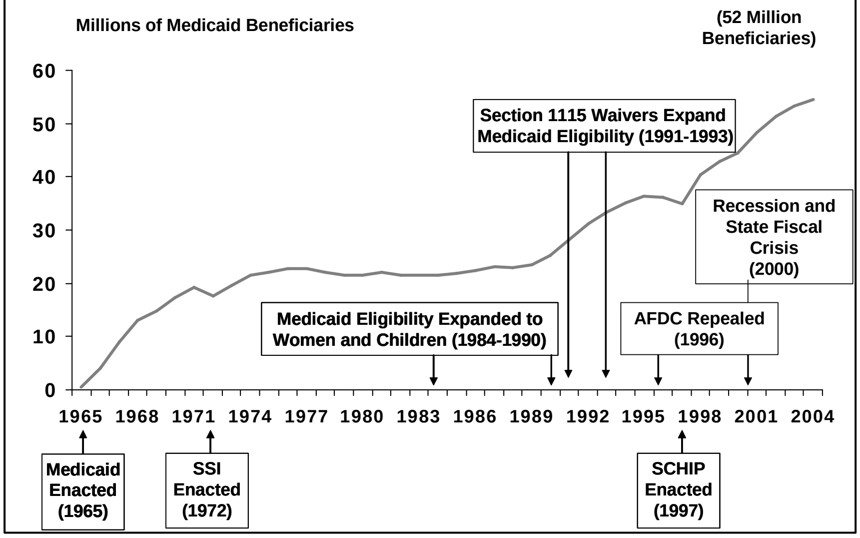
From: Pew Center on the States, *Special Report on Medicaid: Bridging the Gap between Care and Costs*, January 2006.

In general, Medicaid covers a broad range of acute care services, including physician visits, prescription drugs, inpatient and outpatient hospital services, x-rays, and laboratory tests. Medicaid is also a critical source of funding for long-term care services, including nursing homes, intermediate care facilities for the mentally retarded, and home health care services. Over one-third of Medicaid expenditures in 2004 were for long-term care services, primarily for the elderly and people with disabilities.[7] Although they represent a minority of the covered population, the majority of Medicaid spending is for services provided to the elderly and people with disabilities.

One of the most significant recent changes to the Medicaid program was the implementation of the Medicare prescription drug benefit in January 2006, also known as Medicare Part D. With this change, responsibility for prescription drug coverage for dual eligibles was largely shifted from state Medicaid agencies to the Medicare program. States, however, will continue to fund a portion of the cost of this benefit, as well as provide medications excluded from Part D, such as certain excluded classes of drugs and over-the-counter medications. Other recent changes have afforded states more flexibility in Medicaid program design, allowing some to use Medicaid as a platform for expanding health insurance coverage to previously uninsured populations. Over its 40-year history, Medicaid has become an increasingly important source of health insurance funding for vulnerable populations and the safety-net providers who serve them.

Figure 2

Medicaid Eligibility Milestones, 1965-2003



From: Diane Rowland, Executive Director, Kaiser Commission on Medicaid and the Uninsured, and Executive Vice President, Kaiser Family Foundation Testimony before the Medicaid Commission, January 25, 2006.

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[7] Kaiser Commission on Medicaid and the Uninsured. (2006, May). *The Medicaid program at a glance*. Washington, D.C.

The Deficit Reduction Act

A second significant development during the course of the Commission's deliberations was the enactment of the Deficit Reduction Act of 2005 (DRA) on February 8, 2006. The DRA authorized CMS to implement several of the recommendations from the Commission's first report including changes to pharmacy reimbursement policy, restrictions on provider taxes, and the closing of several loopholes in the Medicaid eligibility rules to deter individuals from transferring assets to qualify for long-term care services.

The DRA went well beyond the recommendations from the first Commission report in making changes to the Medicaid program. Most notably, the DRA provided states with substantial additional flexibility to design their Medicaid programs. States may now provide home- and community-based services to eligible populations as an optional service without seeking a waiver and can cap enrollment for these services. Additional options provided to states through the DRA include the ability to increase enrollee cost-sharing obligations and to provide certain eligible populations with more limited benefit "benchmark" insurance packages that are modeled after the State Children's Health Insurance Program. Congress also lifted the moratorium on the development of new Long-Term Care Partnership Programs, allowing states to promote individual responsibility for planning for long-term care needs by creating incentives for their residents to purchase long-term care insurance.

The DRA also provided funding opportunities for states to implement innovative changes to their Medicaid programs. Congress appropriated $150 million over two years for Medicaid Transformation Grants intended to support state efforts to improve the effectiveness and efficiency of providing Medicaid benefits. A "money follows the person" demonstration program will support state efforts to move enrollees from nursing homes to community-based care and encourage consumer-directed benefit designs.

While the DRA included several provisions to increase state flexibility and promote innovation, the legislation included some mandates. Effective July 1, 2006, states must require most new Medicaid applicants to provide proof of U.S. citizenship. As mentioned above, Congress also tightened the Medicaid eligibility criteria by changing the rules governing asset transfers, with which states must comply. The DRA included other mandates as well, in areas such as payment practices for medications, and fraud and abuse prevention and reporting.

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 in general, have put budgetary pressure on both the federal and state governments. Medicaid supports almost half of all long-term care expenditures nationally, and that spending 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 uninsurable people with disabilities; cover institutional long-term care in the absence of any other meaningful financing; shore up the finances for safety-net providers; and subsidize the training of new physicians. 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, including 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.

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 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 Medicaid program remains. The Commission realized an opportunity to consider reform proposals that could significantly impact the future and structure of the Medicaid program. Their deliberations, however, occurred in the context of the many challenges facing the 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.[8]

The Medicaid program has just experienced a period of significant growth. Medicaid enrollment increased by 36 percent from 1999 to 2004 and federal Medicaid spending increased by 64 percent over the same period.[9] 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.[10] State level coverage expansions also contributed to the increase in enrollment and expenditures.

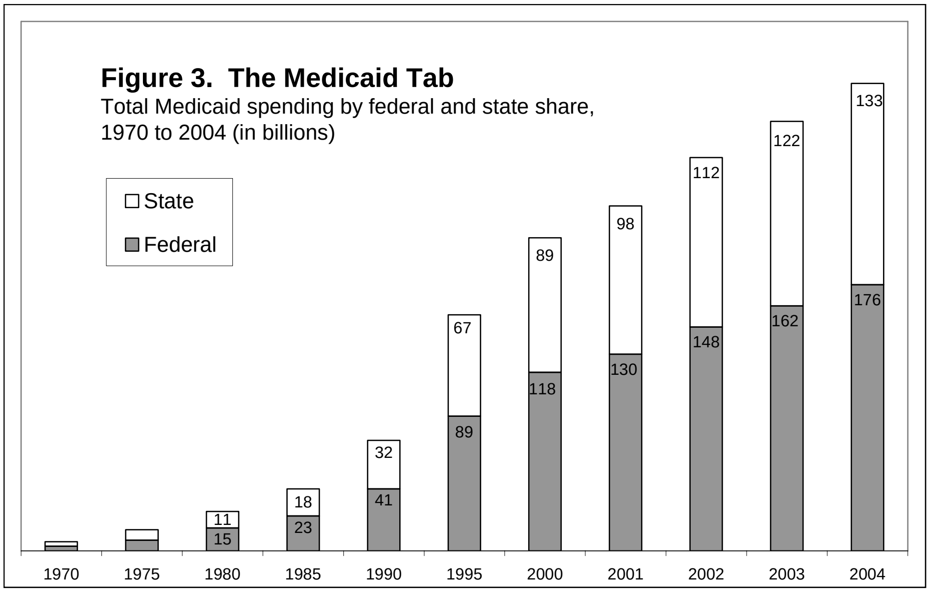
Figure 3. The Medicaid Tab
Total Medicaid spending by federal and state share, 1970 to 2004 (in billions)

From: 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 pressures in the future unless the program undergoes major structural reform.

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[8] National Governors Association and National Association of State Budget Officers. (2006, June). *The fiscal survey of states*. Washington, DC.

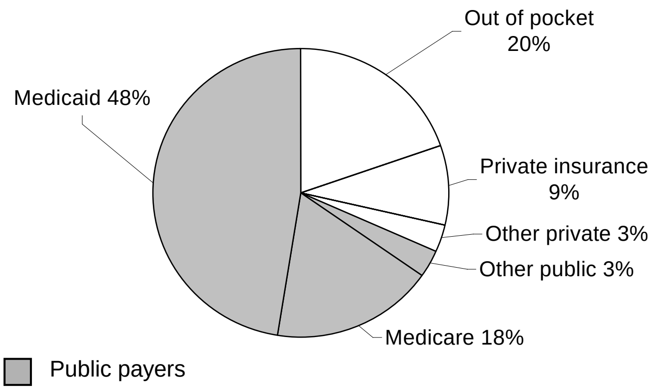
[9] Congressional Budget Office. (2006, July 13). Testimony before the Special Committee on Aging, United States Senate. *Medicaid spending growth and options for controlling costs*.

[10] Holahan, J., & Cohen, M. (2006, May). Kaiser Commission on Medicaid and the Uninsured. *Understanding recent changes in Medicaid spending and enrollment growth between 2000-2004*. Washington, DC.

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 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 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. Furthermore, the three-year time lag in available income data means that the Federal Medical Assistance Percentage (FMAP) is often out of sync with the current economy and therefore does not 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 given the current funding and benefit structure.

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.[11] 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

Figure 4. Funding Sources for Long-Term Care, 2003



Note: Amounts do not include unpaid care provided by family members or other informal caregivers

From: 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.

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[11] O'Brien, E. (2004, May). Kaiser Commission on Medicaid and the Uninsured. *Medicaid and long-term care*. Washington, DC.

such as determining the appropriate role for government financing of long-term care services and examining the government's role regarding encouraging private financing of long-term care services.

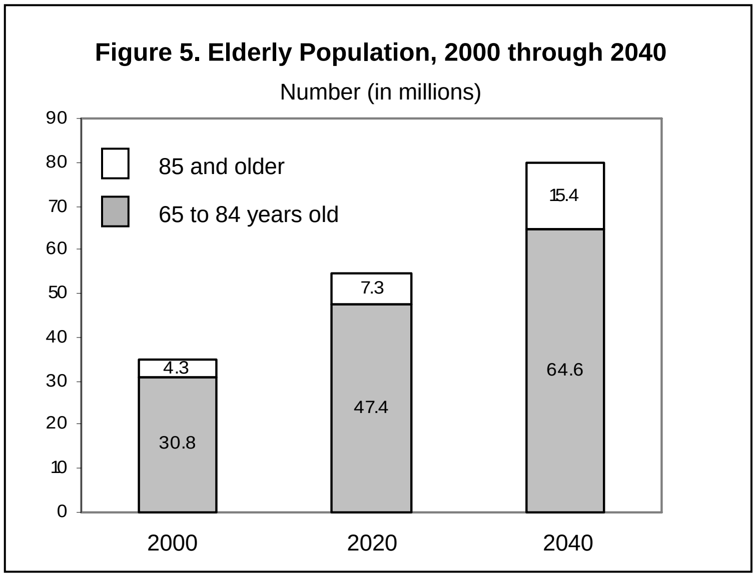
Figure 5. Elderly Population, 2000 through 2040

Number (in millions)

From: 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 Medicaid program has an "institutional bias." Although the DRA included a number of provisions to expand the availability of home- and community-based services (HCBS) as an alternative to institutional care in a setting such as a nursing facility—including a new state-plan HCBS option, a "money follows the person" demonstration initiative, and several new laws to promote self-directed care—Medicaid continues to have a strong statutory and regulatory bias toward institutional care. Several examples illustrate this point. First, nursing facility care is an entitlement and enrollment in this setting cannot be capped. The same is not true of HCBS. Second, federal law prohibits using Medicaid funds to pay for non-medical food and shelter expenses for individuals living in the community, even though Medicaid pays health care providers for these services when they are delivered during an institutional stay. Finally, the income eligibility rules between community-based eligibility and institutionally based eligibility do not always align. As a result, some individuals qualify for Medicaid only if they reside in an institution, and not if they choose to live in the community.

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 eligible population is comprised of individuals with disabilities who are under the age of 65, while two thirds are low-income seniors. Although dual eligibles 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.[12] Health care expenditures for full benefit duals—those dual eligibles who qualify for full Medicaid benefits—are more than twice that for non-dual Medicare beneficiaries.[13]

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[12] Holahan, J., & Ghosh, A. (2005, July). Kaiser Commission on Medicaid and the Uninsured. *Dual eligibles: Medicaid enrollment and spending for Medicare beneficiaries in 2003*. Washington, DC.

[13] Ryan, J., & Super, N. (2003, September 30). National Health Policy Forum. *Dually eligible for Medicare and Medicaid: Two for one or double jeopardy?* Washington, DC.

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 of 2003 introduced Medicare Advantage Special Needs Plans (SNPs) 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. Legislative authority for SNPs will expire on January 1, 2009 absent Congressional action to reauthorize the program, adding uncertainty to the use of this approach by the states. Despite the fact that dual eligibles represent a low percentage of all Medicaid beneficiaries, their relatively high costs and special health care needs, have made them a focus of many Medicaid reform proposals.

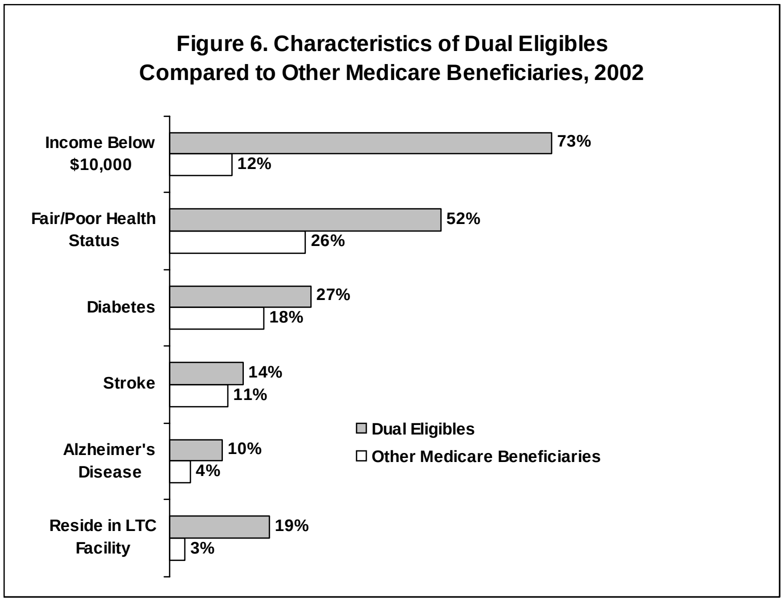


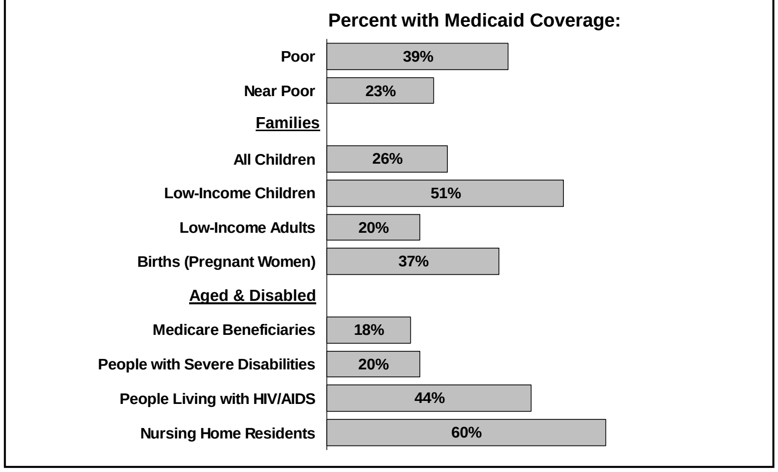
Figure 6. Characteristics of Dual Eligibles Compared to Other Medicare Beneficiaries, 2002

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

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 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 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.[14]

Figure 7. Medicaid's Role for Selected Populations



From: Diane Rowland, Executive Director, Kaiser Commission on Medicaid and the Uninsured, and Executive Vice President, Kaiser Family Foundation, Testimony before the Medicaid Commission, January 25, 2006.

Existing barriers impede the wide dissemination of information technology in health care. Information technology has the potential to improve both the quality and cost of health care in several areas, such as reducing medical errors, improving compliance with clinical practice guidelines, and increasing efficiency by avoiding service duplication.[15] As the largest single purchaser of health care services in the nation, HHS 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 alone spent $600 billion in the U.S. health care system in 2006. As such, HHS 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 and fails to consider estimated long-term savings (savings occurring after 5 years). Passing legislation that is scored as a substantial federal expenditure is difficult when there are competing interests for scarce federal dollars. In addition, 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.

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[14] DeNavas-Walt, C., Proctor, B. D., & Lee, C. H., U.S. Census Bureau. (2006, August). *Income, poverty, and health insurance coverage in the United States: 2005*. Current population reports, P60-231. Washington, DC: U.S. Government Printing Office.

[15] Institute of Medicine. (2001). *Crossing the quality chasm*. Washington, DC: National Academy Press.

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 recognizing the long-term value of investments in quality, supporting state flexibility, and 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 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. 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. 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 alone will not be enough to counteract the inevitable 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 a wider array of long-term care expenditures. Lastly, participating in the Long-Term Care Partnership Program is an option for states to provide such incentives.
- Provide new 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.
- The Commission recommends a study of policy options for using alternative insurance models for the provision of long-term care services. This study should include analyses of costs, revenue and governmental administration.

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 (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 also 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. While the Commission would like to be hopeful that private investment will ease the burden on Medicaid for long-term care expenses, we also recommend a study of policy options for using alternative insurance models to provide for long-term care services, should these measures fall short.

2. Changes in Medicaid long-term care policy should address institutional bias and 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 in a place they call home.

- 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, the Centers for Medicare and Medicaid Services (CMS), and Congress should be encouraged to utilize existing Medicaid resources to maintain and/or incorporate long-term care services within Medicaid State Plans that include nursing facilities, personal care, respite care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), home health, adult day services and other services currently offered in state plans and as Home- and Community-Based Services (HCBS). 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. The Commission wants Congress to go even further by eliminating the institutional bias in areas that the DRA did not reach. 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 establish separate eligibility criteria for acute and preventive medical care services and for long-term care services and supports and the flexibility with benefit design to allow states the option to offer premium assistance to allow buy-in to job-based coverage or to purchase other private insurance.

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). To maintain consistency with the benefit flexibility provisions included in the DRA, federal minimum standards could require states to offer Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage as a wrap-around benefit to populations under age 19.

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 benefit packages that are more aligned with the needs of each population and more closely match standard private market benefit packages, states can better control Medicaid expenditures. Separating eligibility for acute care benefits from eligibility for long-term care benefits will give states the ability to better predict the budget for long-term care services and supports. States that pursue these options, however, must ensure that Medicaid beneficiaries have access to an adequate provider network that can properly deliver services for the covered benefits within that model.

The Commission is also 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. States should be allowed to expand this option or provide uninsured persons access to basic benefit packages without a waiver when meeting federal cost neutrality requirements. Medicaid agencies need the flexibility to support private sector (e.g., employer) investments in health insurance coverage by offering premium assistance to purchase private benefit packages in lieu of full Medicaid benefits. Benefit flexibility provisions should support state Medicaid agency efforts to capitalize on opportunities to engage with private sector health insurance contributions.

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 making and keeping 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 choice for how to spend 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.

4. Compliance with existing regulations regarding the public notice and comment period about state proposals that would significantly restructure Medicaid (1115 waivers and state plan amendments) should be monitored and enforced.

Existing federal and state laws and regulations regarding opportunities for public comment about significant changes to the Medicaid program should be enforced so that stakeholders (e.g., beneficiaries, providers, family members) may provide input as new programs and delivery models that affect them are developed and implemented. The information and perspectives offered during public comment periods are important feedback that must be elicited when state Medicaid agencies pursue policies that would restructure their programs.

C. Eligibility

1. Medicaid eligibility should be simplified by permitting states to consolidate and/or redefine 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. 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 categories without needing a waiver when cost-neutral to the federal government. The Commission does not intend for any currently mandatory eligibility categories to lose coverage with the implementation of this recommendation.

2. The federal government should provide new options for the uninsured to obtain private health insurance through refundable tax credits or other targeted subsidies so they do not default into Medicaid.

The existing tax structure offers many incentives for providing and accessing employer-based health insurance coverage. Yet even with these incentives, employers and employees are finding it increasingly difficult to afford employer-based coverage. In the absence of other federal financing strategies to encourage insurance coverage for these individuals, many end up in Medicaid. The Commission recommends that the federal government provide new options for uninsured individuals to obtain private health insurance using tax credits and other targeted subsidies, in an effort to encourage the development of solutions other than public program expansions for covering the uninsured.

3. Medicaid's core purpose is to serve needy low-income individuals, especially the most vulnerable populations. Therefore, the Commission recommends a study of a new "scaled match" funding formula in which the federal government would reimburse states at an enhanced matching rate for adding lower-income populations to the program, with the match rate scaling back as they expand Medicaid to higher-income populations. Fiscal implications, including cost neutrality, should be considered.

The current federal matching formula for Medicaid funding supports eligibility expansions equally, regardless of the income level of the targeted eligibility group. For example, if a given state's FMAP is sixty (60) percent (meaning the federal government pays 60 percent of the health care costs), then this match rate applies equally to all Medicaid-eligible individuals in the state, regardless of their poverty levels. The Commission believes that Medicaid's core purpose is to assist the nation's most vulnerable populations, including low-income individuals. One possible way to encourage states to target expansions at lower poverty levels would be to establish a sliding-scale FMAP so that the FMAP would vary according to the poverty level of the covered individuals. For example, a state might continue to receive its current FMAP for eligible individuals below the federal poverty line (FPL), 75 percent of its current FMAP for eligible individuals between 100 and 250 percent of the FPL, and 50 percent of its FMAP for eligible individuals above 250 percent of the FPL. In this hypothetical example, the scaled match for a state with a 60 percent FMAP would be 60 percent, 45 percent, and 30 percent. Many variations on this example and their implications for total costs should be considered in the study. However, because the Commission did not have time to adequately study this issue and all its ramifications, we recommend that such a study be conducted to explore the feasibility of a scaled match financing model.

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.

Health information technology has the potential to reduce medical errors and increase the efficiency and effectiveness of our health care system.[16] Other industries have demonstrated how technology can improve productivity and efficiency, far exceeding the advances made in the health care industry. Congressional initiatives to support investment in health information technology are hampered, however, by the current budget scoring process. The current scoring method used by the Congressional Budget Office does not adequately capture estimated savings in subsequent years when it scores health information technology legislation.

2. HHS should continue to aggressively promote and support the implementation of health information technology through policy and financing initiatives while ensuring interoperability.

HHS 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. 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 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.

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[16] Institute of Medicine. (2001). *Crossing the quality chasm*. Washington, DC: National Academy Press.

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 should include 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, in effect, extending the provision regarding the installation of interoperable health information technology by contractors (e.g., health plans, providers) to state Medicaid programs.

5. HHS, state Medicaid agencies, and their vendors shall assure that health information technologies that are acquired or upgraded continuously meet federal and state accessibility requirements.

Existing federal law includes accessibility requirements intended to ensure that individuals with disabilities are able to access the information they need to manage their health, in a format suitable to their circumstances. The Commission strongly endorses these existing laws, and therefore recommends that steps be taken to ensure compliance with the letter and spirit of the existing laws. Medicaid beneficiaries should be able to access their health record information in formats that meet their communication preferences. Therefore, the federal government and state Medicaid agencies shall assure that health information technology acquisitions and upgrades continue to meet federal and state accessibility requirements.

E. Quality and Care Coordination

1. States should place all categories of Medicaid beneficiaries in a coordinated system of care premised on a medical home for each beneficiary, without needing 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.[17] Federal barriers that impede the expansion of this successful model to all Medicaid beneficiaries must be removed and states should

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[17] Starfield, B., & Shi, L. (2004, May). The medical home, access to care, and insurance: A review of evidence. *Pediatrics, 113*(5), 1493-1498.

implement models that link beneficiaries with medical homes. At the same time, it is incumbent on states to ensure an adequate network of providers to fulfill the goals of moving all categories of beneficiaries into a medical home. 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.[18]

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, while also providing necessary safeguards, 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 collect and evaluate treatment data, and states and the federal government would monitor the plans to make sure obligations are being met. Plans would be required to

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[18] This definition is modeled after a July 2002 American Academy of Pediatrics Policy Statement.

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.

- **Savings**. States and the federal government should share in savings for dual eligible members that are achieved through innovative care management strategies resulting in improved clinical and financial outcomes.

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 confusing for beneficiaries and cumbersome for states to pursue integration. 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. States and the federal government should share in the savings that result from such programs. The federal government and states should continue to monitor whether the consumer protections that exist in federal and state laws and regulations are adequate, and should make the appropriate modifications, if necessary, to protect consumers. These consumer protections include an adequate provider network to deliver all covered benefits, access to timely services in the event of urgent or emergent needs, access to translation services for non-English speaking patients, and the ability to pursue grievances and appeals. By providing a range of options, we give states the flexibility to identify and pursue the integration option that best meets the needs of their beneficiaries. 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. 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.

4. State Medicaid agencies shall make available to beneficiaries the payments they make 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 payment information available to beneficiaries to encourage prudent consumer purchasing decisions. By providing beneficiaries with information about the payments made to contracted providers, state Medicaid agencies engage beneficiaries 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.

5. In order to pay for quality, states must first be able to measure it. Therefore, states should collect and mine data on how Medicaid money is being spent to determine which programs, providers, and services are effective and which need improvement. Payments to Medicaid providers then should be tied to objective measures of risk- and case-adjusted medical outcomes. This will lead Medicaid to become more patient focused, i.e., funding health care in a way that assures patients are getting the care they need.

Health information technology has tremendous potential for improving the quality of health care. State Medicaid agencies should use technology to create greater efficiencies in gathering information, delivering care, and managing costs. State Medicaid agencies should collect and analyze data that allows them to focus on purchasing efficient and effective health care interventions that yield desirable health outcomes. These quality improvement efforts, however, should not discourage providers from accepting higher-risk patients with more complex medical needs. Therefore, pay-for-performance systems should consider risk- and case-adjusted medical outcomes. State Medicaid agencies should take advantage of health care data to ensure that Medicaid is providing beneficiaries with the care they need to yield positive health outcomes through an efficient delivery system.

6. CMS and Congress should support state innovation to deliver value for taxpayer dollars by purchasing quality health care outcomes as opposed to simply reimbursing for health care processes. The Commission, therefore, recommends that CMS and Congress provide enhanced match and/or demonstration funding, to be recouped from savings over a five-year period, to support upfront investments in quality improvement in targeted areas: development/enhancement of standardized performance measures, particularly for children, persons with disabilities, populations who experience disproportionate health disparities, and the frail elderly; implementation of care management programs targeted at high-risk, high-cost, co-morbid beneficiaries; and the creation of provider-level pay-for-performance programs.

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 will be instrumental in executing this transformation. By providing states with funding for this initiative, CMS and Congress can encourage states to explore new avenues for improving health care quality and purchasing value with taxpayer dollars. 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 the focus is on ways to deliver improved outcomes with the dollars following the care rather than the event.

While supportive of improving health care quality, the Commission exercises a cautionary note that the implementation of fair and appropriate provider-level performance measurement systems is complex. The Commission would not want to see providers discouraged from serving the most difficult and medically compromised Medicaid beneficiaries if the scoring system used to evaluate outcomes incorrectly and crudely measures the provider’s patient mix rather than his/her skills as a professional. Medicaid should not risk the loss of providers for vulnerable populations, especially those who are willing to treat medically fragile patients whose outcomes, based on characteristics of the patients and not providers, may be suboptimal.

CONCLUSION

Over the course of 18 months, the Commission has carefully examined many challenges facing the long-term sustainability of the Medicaid program. We have listened to testimony from many perspectives, including beneficiaries, providers, family caregivers, advocacy organizations, academics, researchers, counties, states, and the federal government. We have evaluated reform options, debated federalism, and balanced fiscal responsibility with beneficiary needs. The work of this Commission has contributed significantly to the dialogue on the sustainability and improvement of the Medicaid program.

In this work, the Commission evaluated a core attribute of the Medicaid program, namely that it is a jointly financed and administered program between the states and the federal government. Any discussion of Medicaid reform necessarily raises the basic issue of federalism. On one extreme is the view that Medicaid should be administered uniformly across the country as a single national program, placing the locus of policy-making control entirely with the federal government. On the other extreme is the view that Medicaid decisions should be left entirely to the states, so that the federal government's role would be minimal and there could be great variation in Medicaid from state to state.

The Commission's recommendations, taken as a whole, are squarely in the center of this debate. The Commission strongly recommends increased state flexibility in many areas to tackle more locally influenced issues, such as the demographics of the Medicaid population or the nature of the provider delivery system. Simultaneously, the Commission recommends a strong federal role to address such issues as health information technology, long-term care financing, and efforts to improve coordination of the Medicare program with state Medicaid programs to better serve dual eligibles, which require a national solution.

While this Commission has accomplished much over the past 18 months, we did identify a number of issues 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 Percentage or FMAP should be examined in a more comprehensive manner for possible reform. The current federal-state financing arrangement was not a part of this Commission's charter, yet the topic was raised several times throughout the course of the deliberations and should remain a topic for future reform discussions, beyond the limited study recommended in this report.

The health care industry workforce may not be sufficient to support our nation's health care system, especially with a significant rebalancing of the long-term care system to increase home- and community-based service options over institutional care. As our nation shifts its focus to provide more home- and community-based services, one concern among policymakers is whether the long-term care labor pool can accommodate the changing needs of the health care system and whether we risk substituting paid services for the informal care giving currently provided by friends and family members. The Commission included a recommendation in this report that Congress, the Administration, and states consider providing tax incentives to encourage those providing informal care to continue those efforts. Given the current labor challenges faced by institutional health care providers, policymakers should consider additional alternatives for addressing the labor pool issues that will result from a changing health care system.

Limited access to affordable housing creates barriers to providing cost-effective home- and community-based health care for Medicaid beneficiaries. Several presenters and Commissioners raised concerns about the lack of access to affordable housing as a key driver behind the problem of Medicaid-financed care in institutions such as nursing facilities. It was testified that too many people reside in these institutions for lack of access to affordable and available housing. For Medicaid beneficiaries who, by definition, have limited incomes, the only affordable option for long-term care services might be in an institution, where Medicaid funds can support the room and board costs. However, the cost of institutional services is often higher than the cost of providing supports to maintain an individual in the community. Addressing the lack of affordable housing is outside the purview of this Commission, but the importance of this issue requires the attention of policymakers.

Finally, the Commission recognizes that Medicaid is only one part of a larger health care system that continues to face challenges in the rate of spending growth, declining private employer-sponsored coverage, and insufficient attention to purchasing quality care. While the recommendations included in this report are significant, they address only one part of the larger national health care system. There are forces affecting the larger national health care system that Medicaid, alone, cannot impact. The Commission's charge was to lay the groundwork for ensuring the long-term sustainability of the Medicaid program and we have fulfilled that charge. Yet we recognize that many individuals in this country are struggling to pay for adequate health insurance coverage and too many are going without. Congress, HHS, and stakeholders must continue the necessary work on our nation’s overall health care challenges to chart a fiscally responsible path for providing health care to our nation.

APPENDIX A

Vote Summary: Final Recommendations

The Medicaid Commission consisted of fifteen voting members. The final vote, in support of the recommendations contained in the enclosed report, was 11-1, with one abstention and two Commissioners not present. The record of the final vote was as follows:

Aye: 11 (Sundquist, King, Atkins, Bella, Christopher, Helms, Justesen, McCann, Regier, Shiebler, Turner)

Nay: 1 (Gillenwater)

Abstain: 1 (James)

Not Present: 2 (Bush, Manchin)

APPENDIX B

Dissenting Reports

Gwen Gillenwater, American Association of People with Disabilities

On behalf of low-income Americans with disabilities, I respectfully dissent from the final report adopted by the Commission on November 17, 2006. Because I am limited to two pages, I will focus on three major concerns, although it should be noted that the report contains other equally problematic recommendations and also fails to address many critical issues in Medicaid. In particular, it fails to address the crisis of having an adequate support workforce or the basic structural flaws in the Medicaid program.

My first concern is the Commission's failure to deal with Medicaid's institutional bias, the most egregious flaw in the current program and the reason I welcomed the invitation to serve on the Commission. A number of disability advocacy coalitions have made this issue a top priority for years. Although there has been a gradual shift away from nursing homes to home- and community-based services (HCBS), John Lancaster, executive director of the National Council on Independent Living, testified before the Commission that in fiscal year 2005, only 37 percent of Medicaid expenditures for long-term services were for HCBS. But as Lancaster also noted, some states remain well behind in providing HCBS. For example, Tennessee spent a negligible 0.6 percent of its long-term services budget on HCBS in 2005.

Medicaid beneficiaries who meet a state's criteria for receiving care in a nursing home or other institution are entitled to that care. But if they want HCBS, they are often subject to waiting lists in state HCBS waiver programs. Waiting lists are both large and long. More than 206,000 people are estimated to be waiting for Medicaid HCBS services, and in some states, the wait for services can last more than two years.

The Commission's recommendations regarding institutional bias would do nothing to give Medicaid beneficiaries a true choice between HCBS and nursing homes and do nothing to address the myriad of state policies and programs that determine who can and cannot qualify for HCBS. The recommendations relating to institutional bias (A. 2.) simply restate the obvious: "Changes in Medicaid long-term care policy should address institutional bias…New Medicaid policy should respect beneficiary preferences…In most cases, home- and community-based services are less expensive than institutional services and preferable to the beneficiary." These recommendations may make some people feel good, but they will do absolutely nothing to ensure that all low-income Americans at risk of institutional care have the option of receiving HCBS services, regardless of the state in which they live. This is inexcusable.

My second concern is the Commission's recommendation (E.2) to "promote" the enrollment in managed care arrangements of "dual eligibles," the 7 million Americans who are eligible for Medicare and, because of their low incomes and resources, for Medicaid as well. As the Commission heard repeatedly, these individuals are among the most vulnerable populations served by Medicaid.

No one disputes that many dual eligibles would greatly benefit from improved coordination of Medicaid and Medicare services. The question is how best to accomplish this while also providing appropriate protections that guarantee choice and control for these individuals. State efforts to experiment with new models for integrating services are limited and new; we should not mandate participation of vulnerable beneficiaries until we have well-developed and proven methods of delivering integrated services. The Commission recommends that states be allowed to integrate acute and long-term care benefits/services for dual eligibles through special needs plans "or other mechanisms" by enrolling all dual eligibles in these plans or "other mechanisms" automatically. In theory, dual eligibles would have the ability to "opt out" and return to return to regular Medicaid or Medicare.

Just two days before the Commission voted to approve this recommendation, a front-page *Wall Street Journal* article reported that some Medicaid HMOs "restrict medical tests and use of prescription drugs" and "spend the money they get from states on items that don't have an obvious connection to patients," such as executive compensation, entertainment, political contributions, and profit for shareholders ("In Medicaid, Private HMOs Take a Big, and Lucrative, Role," November 15). The article quoted several clients who had difficulty accessing network providers for needed care.

In light of this article, I believed there would be concern within the Commission about enrolling dual eligibles, who have such extensive medical needs, into "other mechanisms" like Medicaid HMOs that have a financial incentive *not* to furnish services. Yet the Commission's recommendation makes only a passing reference to "providing necessary safeguards," and when I offered an amendment to specify minimum patient protections, it was rejected by a vote of 11-1. I cannot in good conscience support a recommendation that allows automatic enrollment of dual eligibles into "other mechanisms" without minimum protections to ensure the individual's right to appropriate, functionally necessary services and equipment.

My final concern relates to the recommendation that "Federal Medicaid policy should … reward beneficiaries who make prudent purchasing, resource-utilization, and lifestyle decisions" (B.2). This patronizes millions of low-income Americans with disabilities who face enormous personal challenges every day. It assumes that they are not prudent purchasers, do not use limited health care resources efficiently, and have undesirable lifestyles, and that rewarding them will make them more responsible citizens.

The recommendation is particularly ironic given that the Commission did nothing to address Medicaid's institutional bias. If Americans with disabilities had a real choice between institutional and HCBS services, they would be able to make prudent decisions, use limited health care resources efficiently, and live in the community rather than an institution. I have no doubt whatsoever that they would take advantage of that opportunity if it were presented.

Americans with disabilities need Medicaid reform that enhances integration, inclusion, and independence, not personal responsibility "rewards." As their representative, I respectfully dissent from the final recommendations approved by the Commission.

Robert B. Helms, Resident Scholar, American Enterprise Institute

I voted for the final report and for all of the specific proposals approved by the Medicaid Commission because I believe that the final recommendations provide a long-overdue and helpful roadmap that offers useful reforms of the program. I am submitting this dissenting statement[1] because I believe that the Commission's recommendations affecting the long-term financial sustainability of the program (Recommendations A1, B1-4, C1-3) did not adequately address a critical issue that will be essential for fundamental reform.

Medicaid has an out-dated and ill-conceived method for determining the level of federal financial support to the states. Until this issue is addressed, and a fairer and more equitable method is developed, Medicaid will continue to be plagued by serious problems, including:

- poor targeting of resources to help the poorest and most disadvantaged members of our country;
- uncontrolled growth of federal and state spending;
- rampant amounts of fraud and abuse;
- strong incentives for states to use questionable accounting schemes to increase federal funding;
- federal subsidies that are slow to respond to changing economic conditions in the nation or in the states; and
- intensifying adversarial relationships between the states and the federal government that reduce the chance of political compromise on policy reforms.

The basic procedure for determining the amount of federal dollars that flow to the states is determined by the Federal Medical Assistance Percentage (FMAP) formula. This formula compares each state's per capita personal income to the national per capita personal income and is designed to provide larger federal Medicaid subsidies to states with relatively low incomes, and vice versa. The FMAP formula determines only the percentage rate at which the federal government matches claims submitted by the states. The total amount of federal funds flowing to each state is also a function of the number of claims that a state submits to cover the costs of providing mandatory and optional benefits for mandatory and optional beneficiaries.

To illustrate how the current financing system has failed to allocate federal subsidies to the poorest populations, consider the following data on the distribution of federal Medicaid payments. In 2004, the latest year of Medicaid data available from CMS, federal Medicaid payments to the states ranged from a low of $233 *million* to Wyoming to a high of $21.4 *billion* to New York. Federal Medicaid payments can also be expressed on a per capita basis by dividing Federal payments by the number of low income people in poverty (below 125% of the Federal Poverty Level) in each state. That figure is independent of each state's Medicaid eligibility policies. These per capita federal payments in FY 2004 ranged from $1,736 in Nevada to $6,780 in Maine. Data

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[1] A more detailed report containing supporting data, charts, and references is available at www.aei.org.

for all states reveal that there is a negative relationship between the per capita amount of federal funds flowing to the states and the amount of poverty in the states – that is, as a general tendency, the poorer the state, the less federal funds per low-income person that state receives. States with the highest poverty rates, such as the Katrina states, received much lower Medicaid payments per capita (AL, AR, LA, MS, and TX averaged $2,585) than did wealthier states like New York and several New England states (CT, MA, NH, NY, and VT averaged $5,848).[2]

Not only can the wealthier states afford to spend more on Medicaid, the open-ended federal government match creates a strong incentive for states to increase Medicaid spending relative to all other priorities. When a state is forced to cut budget expenditures, a state has an incentive to cut unmatched expenditures instead of matched state expenditures. With a minimum matching rate of 50 percent, a state would have to cut total Medicaid expenditures by $2 in order to reduce state expenditures by $1. This incentive results in a ratchet effect in state Medicaid budgets which tend to rise in good times but are not reduced when states must cut back.

Clearly, federal matching has not achieved the intended objectives of Medicaid. Poorer states today are falling behind as wealthier states garner a greater share of federal Medicaid dollars. The FMAP formula also does a poor job of counteracting the effects of changes in a state's economic activity. The measurement of a state's per capita personal income does not accurately track changes in state economic activity, and the three-year averaging procedure, as well as delayed updating, results in a substantial lag in FMAP adjustments. If a state's economy begins to decline relative to other states, it may take from three to six years for the FMAP to adjust to this change.

Open-ended federal matching has been criticized for decades by experts representing a wide spectrum of policy views and philosophical approaches to health policy. The debate is not just a matter of trying to reduce federal outlays. The perverse incentives created by this method of financing would be present at any level of spending. A recent report by the National Academy of State Health Plans refers to the Medicaid "Tug of War" and calls for steps to improve the fiscal integrity of federal financing. Numerous analysts over the years have pointed out that each governor and state congressional delegation has a strong incentive to increase federal funding under the FMAP procedure rather than consider reforms that would be in the best interests of the populations Medicaid is intended to serve.

The extensive literature on Medicaid reform provides numerous ideas about how to correct these perverse incentives and assure that the program focuses on helping the poorest and most vulnerable of our citizens. The Commission's recommendation to study a system of scaled-match funding (C3) is a start, but does not represent the much-needed complete reform of the FMAP approach. Until this issue is addressed, the budgetary and policy deficiencies that led to the formation of this Commission will continue to fester.

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[2] Preliminary CMS data for FY 2005 shows a very similar pattern.

APPENDIX C

CHARTER

MEDICAID COMMISSION

Purpose

The Secretary of the Department of Health and Human Services is establishing a Medicaid Commission under Public Law 92-463, Federal Advisory Committee Act, to advise the Secretary on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in a financially sustainable way.

Authority

42 U.S.C. 217a, section 222 of the Public Health Service Act, as amended. The Medicaid Commission is governed by the provisions of Public Law (P.L.) 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

Function

The Commission shall submit two reports to the Secretary for his consideration and submission to Congress. By September 1, 2005, the Commission will provide recommendations on options to achieve $10 billion in scorable Medicaid savings over five years while at the same time make progress toward meaningful longer-term program changes to better serve beneficiaries. The Commission will also consider, to the extent feasible, specific performance goals for the Medicaid program, as a basis for longer-term recommendations. By December 31, 2006, the Commission is tasked with making longer-term recommendations on the future of the Medicaid program that ensure the long-term sustainability of the program.

The Commission shall develop proposals that address the following long-term issues:

- Eligibility, benefits design, and delivery
- Expanding the number of people covered with quality care while recognizing budget constraints;
- Long term care;
- Quality of care, choice, and beneficiary satisfaction;
- Program administration; and
- Other topics that the Secretary may submit to the Commission.

The Secretary will request the representatives of the three public policy organizations (as referenced below) to consider these issues and provide relevant information to the Commission within specified timeframes. The Commission shall consider how to address these issues under a budget scenario that assumes federal and state spending under the current baseline; a scenario that assumes Congress will choose to lower the rate of growth in the program, and a scenario that may increase spending for coverage. The Commission shall assume that the basic matching relationship between the federal government and the states will be continued.

Structure

The Commission shall consist of three types of member groups, of which only one will have the authority to vote on the recommendations to be provided to the Secretary. The first group will consist of up to 15 voting members.

Voting Members:

- Former or current Governors
- Three representatives of public policy organizations involved in major health care policy issues for families, individuals with disabilities, low-income individuals, or the elderly.
- Former or current State Medicaid Directors
- Individuals with expertise in health, finance, or administration
- Federal officials who administer programs that serve the Medicaid population
- The Secretary (or the Secretary's designee) and such other members as the Secretary may specify.
- Ex Officio Members

Non-Voting Advisor Members:

A group of up to 15 non-voting advisors will support the Commission's deliberations with their special expertise. These will include state and local government officials, consumer and provider representatives who have an inherent interest in the Medicaid program.

Non-voting Congressional Advisor Members:

The Congressional Members will consist of eight non-voting members who are current members of the Senate and House of Representatives. The Secretary will request the following legislative leaders to make one Congressional selection each:

- Senate Majority Leader
- Senate Minority Leader
- Chairman, Senate Finance Committee
- Ranking Member, Senate Finance Committee
- Speaker, House of Representatives
- Minority Leader, House of Representatives
- Chairman, House Committee on Energy and Commerce
- Ranking Member, House Committee on Energy and Commerce

The Secretary shall designate a voting member to serve as the Chairperson. Members shall be invited to serve for the duration of the Commission.

A quorum for the conduct of business shall consist of a majority of currently appointed voting members.

As necessary, subcommittees composed of members of the parent committee, may be established to perform functions within the commission’s jurisdiction. The Department Committee Management Officer shall be notified upon the establishment of each standing subcommittee and shall be given information on its name, membership, function, and estimated frequency of meetings.

Management and support services shall be provided by the Department of Health and Human Services.

Meetings

Meetings shall be held up to 6 times per year at the call of the Chair, with the advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings shall be open to the public except as determined otherwise by the Secretary or other official to whom the authority has been delegated; notice of all meetings shall be given to the public.

Meetings shall be conducted and records of the proceedings kept, as required by applicable laws and Departmental regulations.

Compensation

Members who are not full-time Federal employees shall be paid at the rate of $250 per day. Members of the Commission shall be entitled to receive reimbursement of travel expenses and per diem in lieu of subsistence, in accordance with Standard Government Travel Regulations.

Annual Cost Estimate

Estimated cost for operation of the Commission, including travel and per diem for members, and logistical support, but excluding staff support is $1,449,800 for FY 2005 and $2,025,800 for FY 2006 and 744,600 for FY 2007. The estimated annual costs of staff support required are estimated at $358,438 for FY 2005 and $862,189 for FY 2006 and $429,955 for FY 2007.

Reports

By not later than September 1, 2005, the Commission shall submit to the Secretary a report that contains a detailed proposal (including specific legislative or administrative recommendations) to achieve $10 billion in reductions in the rate of Federal Medicaid spending over a period of 5 years.

By not later than December 31, 2006, the Commission shall submit to the Secretary a report that contains a detailed proposal (including specific legislative or administrative recommendations) and such other recommendations as the Commission deems appropriate on longer-term methods of modernizing the Medicaid program.

In the event a portion of a meeting is closed to the public, a report shall be prepared which shall contain, at a minimum, a list of members and their business addresses, the Commission's function, dates and places of meetings, and a summary of Commission activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee Management Officer.

Termination Date

The Medicaid Commission shall terminate 30 days after the date of the submission of the final report to the Secretary, but no later than January 31, 2007.

APPROVED:
MAY 19 2005
Date

Secretary

APPENDIX D

Roster of Meetings

October 26-27, 2005

January 24-26, 2006

March 13-15, 2006

May 17-18, 2006

July 11-12, 2006

September 6-7, 2006

November 16-17, 2006

APPENDIX E

Presenters

October 2005 Meeting
Charles Milligan, Jr., J.D., M.P.H, Executive Director, Center for Health Program Development and Management, UMBC
Gayle Sandlin, Director, CHIP Program, Alabama Department of Public Health
Roy Jeffus, Director, Division of Medical Services, Arkansas Department of Human Services
Melanie Bella, Commissioner and Vice President for Policy, Center for Health Care Strategies, Inc.
Anthony “Tony” Rodgers, Director, Arizona Health Care Cost Containment System

January 2006 Meeting
Honorable Secretary Michael Leavitt, U.S. Department of Health and Human Services
Charles Milligan, Jr., J.D., M.P.H., Executive Director, Center for Health Program Development and Management, UMBC
Diane Rowland, Executive Director, Kaiser Commission on Medicaid and the Uninsured, and Executive Vice President, Kaiser Family Foundation
Nina Owcharenko, Policy Analyst, Heritage Foundation
Joy Johnson-Wilson, Commissioner and Federal Affairs Counsel and Director of the Health Committee, National Conference of State Legislatures
Jim Frogue, State Project Director, Center for Health Transformation
John Holahan, Director, Health Policy Center, Urban Institute
Lynn Etheredge, Independent Consultant
Honorable Dirk Kempthorne, Governor of Idaho
Karl Kurtz, Director, Idaho Department of Health and Welfare
David Rogers, Idaho Medicaid Director
Honorable Mitt Romney, Governor of Massachusetts
Beth Waldman, Massachusetts Medicaid Director
Tim Murphy, Massachusetts Secretary of Health and Human Services
Nancy Atkins, Commissioner and Commissioner, Bureau for Medical Services, West Virginia Department of Health and Human Resources

March 2006 Meeting
Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services
Kathryn G. Allen, Director, Health Care, U. S. Government Accountability Office
Janet O’Keefe, Dr.PH, R.N., Senior Researcher and Policy Analyst, Program on Aging, Disability and Long-Term Care, RTI International
Charles Milligan, Jr., J.D., M.P.H., Executive Director, Center for Health Program Development and Management, UMBC
Judy Xanthopoulos, Quantria Strategies, LLC
Barbara Stucki, National Council on the Aging
Marc Cohen, Lifeplans, Inc.

Honorable Jeb Bush, Governor of Florida
William Ditto, Director, New Jersey Division of Disability Services
Shelly Brantley, Director, Florida Agency for Persons with Disabilities
Kathryn Lawler, Atlanta Regional Commission

May 2006 Meeting
Ernest McKenney, Consultant
Bob Kafka, National Organizer, ADAPT and Co-Director, Institute for Disability Access
Dr. David Jacox, President and CEO, Mosaic
Richard Browdie, President and CEO, Benjamin Rose
Larry Minnix, President and CEO, American Association for Homes and Services for the Aging
Bruce Yarwood, President and CEO, American Health Care Association, National Center for Assisted Living
Patrick Flood, Commissioner, Vermont Department of Aging and Disabilities
Charles Milligan, Jr., J.D., M.P.H., Executive Director, Center for Health Program Development and Management, UMBC
John Mach, Jr, M.D., CEO, Evercare
Robert Master, M.D., President, Commonwealth Care Alliance
Pamela Coleman, Director, Medicaid/CHIP Health Plan Operations, Texas STAR+PLUS
Donna Frescatore, Deputy Directory, Office of Managed Care, New York
Lisa Alecxih, Vice President, The Lewin Group
Martha Roherty, Director, National Association of State Medical Directors and Center for Workers with Disabilities, American Public Human Services Administration
Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services

July 2006 Meeting
Carolyn Clancy, M.D., Director, Agency for Healthcare Research and Quality
Jean D. Moody-Williams, R.N., M.P.P., Division Director, Division of Quality, Evaluation, and Health Outcomes, Center for Medicaid and State Operations, Center for Medicare and Medicaid Services
Alan G. Rosenbloom, President, Alliance for Quality Nursing Home Care
Donald M. Berwick, M.D., M.P.P., President and Chief Executive Officer, Institute for Healthcare Improvement and Clinical Professor of Pediatrics and Healthcare Policy, Harvard Medical School
Maggie Brooks, Commissioner and County Executive, County of Monroe, Rochester, NY
Allen Dobson, Assistant Secretary for Health Policy and Medical Assistance, North Carolina Department of Health and Human Services
Martha Yeager Walker, Secretary, West Virginia Department of Health and Human Services
Sarah B. Chouinard, M.D., Medical Director, Primary Care Systems, Inc. West Virginia
James L. Hardy, Deputy Secretary, Office of Medical Assistance Programs, Pennsylvania Department of Public Welfare

Jeff Goldsmith, Ph.D., President of Health Futures, Inc., Associate Professor of Medical Education, School of Medicine, University of Virginia
Joseph E. Bisordi, M.D., FACP, Associate Chief Medical Officer, Geisinger Health System
Sybil M. Richard, J.D., M.H.A., R.Ph., Assistant Deputy Secretary for Medicaid Operations, Florida Agency for Health Care Administration
David Sundwall, M.D., Executive Director, Utah Department of Health
Christopher F. Koller, Rhode Island, Health Insurance Commissioner
C. William "Bill" Schroth, M.B.A., New York Intergovernmental HIT Work Group, New York Department of Health
Charles Milligan, Jr., J.D., M.P.H., Executive Director, Center for Health Program Development and Management, UMBC
Newt Gingrich, Founder, Center for Health Transformation
William Winkenwerder, Jr., M.D., M.B.A., Assistant Secretary of Defense for Health Affairs

September 2006 Meeting
Charles Milligan, Jr., J.D., M.P.H., Executive Director, Center for Health Program Development and Management, UMBC
Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare and Medicaid Services
Ray Scheppach, Executive Director, National Governors Association
Mark Hayes, Health Policy Director, Senate Finance Committee
Alice Weiss, Health Counsel, Senate Finance Committee
Chuck Clapton, Policy Advisor, Speaker J. Dennis Hastert
Congressman Nathan Deal, Chairman, Subcommittee on Health, House Energy and Commerce Committee

November 2006 Meeting
Charles Milligan, Jr., J.D., M.P.H., Executive Director, Center for Health Program Development and Management, UMBC

APPENDIX F

List of Testifiers During Public Comment Sessions

October 26-27, 2005
Washington, D.C.

Mark Hagen, Lutheran Services in America, Disability Network
James T. Martin, United South and Eastern Tribes
Frank Dayish, Jr., Navajo Nation
Marty Ford, The Arc and United Cerebral Palsy
Bill Vaughan, Consumers Union

January 24-26, 2006
Chevy Chase, MD

Elizabeth Priaulx, J.D., Virginia Office for Protection and Advocacy
Jennifer Graham, KenCrest Lutheran Services in America
Catherine Nold, KenCrest Lutheran Services in America
Jay Grimes, KenCrest Lutheran Services in America
William J. Nolan, CFP, KenCrest Lutheran Services in America
David Alexander, M.D., National Association of Children's Hospitals
Vincent A. Keane, Unity Health Care, Inc.
Cathy Surace, Maryland Disability Law Center
Terry Gilbert, Medicaid Recovery, Inc.
Walter L. Faggett, M.D., D.C. MedChi
Gregory Barkley, M.D., Epilepsy Foundation
James Romano, Patient Services, Inc.
Bennett Lavenstein, M.D., Child Neurology Society

March 13-15, 2006
Atlanta, GA

Katie Beckett, Ticket to Work and Work Incentives Advisory Panel of the Social Security Administration
Irene Welch, VOR
Elliott Palevsky, United Jewish Communities
Marsha Greenfield, American Association of Homes and Services for Aging
Charles Luband, National Association of Public Hospitals and Health Systems
Brenda Blalock
Chris and Christopher Hunicutt
Mark Peterson, Lutheran Social Services of Minnesota
Jeff Lemieux, America's Health Insurance Plans
Mark Andrews, Molina Healthcare
Edward Sheehy, Volunteers of America

Allan Goldman, Georgia Division of Aging Services
Bonnie-Jean Brooks, Maine Association for Community Service Providers
Margaret Puddington, New York, NY
Ken Lovan, ResCare
Tary Brown, Albany Area Primary Health Care, Inc.
Pat Puckett, Statewide Independent Living Council of Georgia
Pat Nobbie, Governor’s Council on Developmental Disabilities
Ashley Rhinehart, Disability Link
Marty Ford, The Arc and United Cerebral Palsy
Suellen Galbraith, American Network of Community Options and Resources
Than Johnson, Champaign Residential Services, Inc.
Leslie and Daniel Estaban
Page Pennell, M.D., Emory University School of Medicine
Melanie Birchfield, Epilepsy Foundation of Georgia
Julie Venners Yannes, Child Neurology Foundation
Malissa Dempsey
Pedro Malu
Jamal Collins

May 17-18, 2006
Irving, TX

Mary Lou Garrett, American Physical Therapy Association
Pete Henning, Bethesda Lutheran Homes and Services
Brandy Haba, Corsicana, TX
Katherine Taylor, Corsicana, TX
Rita Wiersma, Spring Valley, MN
Abbie Totten, Molina Healthcare
Lisa Swanson, M.D., American Academy of Pediatrics and the Texas Pediatric Society
Jason Terk, M.D., American Academy of Pediatrics and the Texas Pediatric Society
Dan Shepherd, Community Health Services Agency
Steve Moses, Center for Long-Term Care Reform
Susan Garnett, Public Mental Retardation Agency
Teresa Norton
Minnie Blackwell
Nancy Davenport
Richard Garnett, M.D., Texas Council on Autism
Ralph Long, Dallas, TX
Aaron Spencer, Houston, TX
Steven Buck, National Alliance on Mental Illness
Brian Coyne, America’s Health Insurance Plans
Nancy Ward, VOR
Richard Hernandez, EduCare Community Living
Carole Smith, Private Providers Association of Texas
Laura Redman, Community Access, Inc.
Sonia White, Nurture, Knowledge, and Nutrition, Central Dallas Ministries

Julia Easley, Dallas Children's Hospital, Dallas Area CHIP Coalition
Angela King, Volunteers of America
Frank Ford, D.D.S.
Jeff Miller, J.D., Advocacy Incorporated
Suellen Galbraith, American Network of Community Options and Resources
Marty Ford, The Arc and United Cerebral Palsy
Leeanne Pearse, M.D., Texas Pediatric Society/American Society of Pediatrics
Donna Thompson, Rockwell, TX

July 11-12, 2006
Arlington, VA

Henrie Treadwell, Ph.D., Community Voices
Roxanne Leopper, First Health of the Carolinas
Karim Bryant, Miami, FL
Dan Derksen, M.D., New Mexico Community Voices
April Young, Miami Community Voices
Jane Browning, International Community Corrections Association
Hrant Jamgochian, American Pharmacists Association
Bob Kay, Lutheran Social Services of Northern New England
Jane Knox-Voina, Brunswick, ME
Wayne and Carolyn Larson, Chaska, MN
Pat Bennett, VOR
Kevin Kearns, Health Choice Network, National Association of Community Health Centers
Peters Willson, National Association of Children's Hospitals
Liz Meitner, Voices for America's Children
Matthew Levy, American Academy of Pediatrics
Catriona Johnson, National Disabilities Rights Network
Marty Ford, Consortium for Citizens with Disabilities, The Arc, and United Cerebral Palsy Disability Policy Collaboration
Mary Shilton, National Consortium of TASC Programs
Paul Seltman, California Association for Adult Day Services
Spencer Perlman, Advocate Health Care

September 6-7, 2006
Arlington, VA

Dan Hawkins, National Association of Community Health Centers
Peters Willson, National Association of Children's Hospitals
Renee Jenkins, M.D., American Academy of Pediatrics
Kevin Burke, American Academy of Family Physicians
Alan Morgan, National Rural Health Association
Howard Weiss, America's Health Insurance Plans
Mary Reese, VOR

Lea Ann Moricle, M.D., National Alliance on Mental Illness, National Council for Community Behavioral Healthcare
Toby Long, PT, Ph.D., American Physical Therapy Association
Bob Judson, Digital Healthcare
Charles Houston, American Congress of Community Supports and Employment Services and Disability Service Providers of America
Cinda Hughes, National Congress of American Indians
John Lancaster, National Council on Independent Living
Marty Ford, The Arc and United Cerebral Palsy
Doris Ray, Independence Center of Northern Virginia
Mary H. Hager, Ph.D., R.D., American Dietetic Association
Elizabeth Priaulx, Delaware Protection and Advocacy Program

November 16-17, 2006
Arlington, VA

Robin Sims, VOR
Andrina Fiene, LSA Disability Network
Ken Ursin, Florida Hospital Waterman
Yvonne Focke
Howard Weiss, America's Health Insurance Plans
Brien Smith, M.D., Epilepsy Foundation and Henry Ford Hospital
Amanda Molk Jezek, March of Dimes
Mim Dixen, Ph.D., American Indian and Alaska Native Health Care
Howard Shapiro, State Associations of Addiction Services
Sandra Holliss, Tourette Syndrome Association
Suellen Galbraith, American Network of Community Options and Resources
Cinda Hughes, National Congress of American Indians
Marty Ford, The Arc and United Cerebral Palsy
Kim Musheno, Association of University Centers on Disabilities
Liz Savage, The Arc and United Cerebral Palsy
Nathan Bradley, Tender Heart Medical Adult Day Care
John Lancaster, National Council on Independent Living
Stacy A. Bohlen, National Indian Health Board

APPENDIX G

COMMISSION GUIDELINES

During Medicaid Commission deliberations, the following two principles shall guide discussion on Medicaid program reform:

a) Changes to the program should further the commitment to providing the highest quality care to beneficiaries, and
b) Consideration of any reform concept should acknowledge the fiscal constraints of state and federal budgets and should contribute towards ensuring the long-term financial sustainability of the program.

The Commission shall develop proposals that address the following long-term issues, as outlined in the Charter:

- Eligibility, benefits design and delivery;
- Expanding the number of people covered with quality care while recognizing budget constraints;
- Long term care;
- Quality of care, choice, and beneficiary satisfaction;
- Program administration; and
- Other topics that the Secretary may submit to the Commission.

The Commission is tasked with making longer-term recommendations on the future of the Medicaid program that ensures the long-term sustainability of the program by December 31, 2006.

APPENDIX H

CRITERIA FOR FINAL RECOMMENDATIONS

The detailed recommendations for the final report must meet certain broad areas of criteria which are agreed upon by Commission members.

These criteria for recommendations lay the broad conceptual framework for choosing specific and detailed recommendations for Medicaid reform.

1) All recommendations must have a major impact on the Medicaid program

The Commission’s recommendations must have a major impact on the Medicaid program. To meet this criterion, the recommendations must affect the program on a national basis, and address a major programmatic aspect of the Medicaid program.

2) All recommendations must address the long-term sustainability of the Medicaid program

Not only must the recommendations have a major impact, they must improve the long-term sustainability of the program.

3) The Commission’s recommendations must comport with the context of fiscal constraints of state and federal budgets

The Commission’s recommendations must not put further demand on the already strained resources of the state and federal governments.

4) The recommendations must not increase the number of uninsured

The Commission’s recommendations cannot erode the likelihood that individuals will secure insurance within the context of the health care system.

5) All long-term care recommendations should honor Secretary Leavitt’s direction

Recommendations regarding long-term care should consider the impact of changing national demographics and strive to encourage: responsibility in financial planning; individuals finding alternatives and strengthened private arrangements; expanded choices and enhanced access to health care services in home and community based settings.