FINAL RECOMMENDATIONS

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.

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

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

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

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

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.